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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05997

CERTIFICATE OF DEATH

05986

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LONA CONING</b>		c. LENGTH OF STAY IN 1b <b>3 WEEKS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>KYLE NURSING HOME</b>		d. STREET ADDRESS <b>112 WEBER STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>ERNEST</b> Last <b>ABERNATHY</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 7, 1902</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GARAGE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>CROSS, W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JESSE G. ABERNATHY</b>		14. MOTHER'S MAIDEN NAME <b>SARAH RANDALLS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214 05 6255</b>	
17. INFORMANT <b>MRS. ZELDA ABERNATHY, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial ischemia</b> DUE TO (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>azotemia with uremia</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (g) <b>Previous Gastrointestinal hemorrhage; generalized arthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 20, 1966</b> , to <b>5/18/1967</b> , that (I) (we) last saw the deceased alive on <b>5/18/1967</b> , and that death occurred at <b>630 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Richard E. Schindler</b>		22b. DATE SIGNED <b>MAY 18, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD E. SCHINDLER, M.D.</b>		22d. ADDRESS <b>69 GREENE ST. CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 20, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>COOK'S MILL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>HYNDMAN BEDFORD PA.</b>	
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>		25. REC'D BY REGISTRAR <b>MAY 22 1967</b>	
CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE <b>J. Charles Jones</b>	

82228

82228

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HONOLULU, HAWAII

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>12 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LA VALE</b>				d. STREET ADDRESS <b>1233 NATIONAL HIGHWAY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JOSEPHINE</b>			First <b>C.</b> Middle <b>ALBERT</b> Last			4. DATE OF DEATH Month <b>MAY</b> Day <b>19</b> Year <b>19 67</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>03-06-23</b>		9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months <b>44</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>SANDYHOOK, MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>WILLIAM COLE</b>						14. MOTHER'S M maiden NAME <b>MARY (COOPER) COLE</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>219-12-2114</b>		17. INFORMANT <b>HOSPITAL RECORDS</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration; Pulmonary Atelectasis</b> 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Right - Pleural Effusion</b> (c) <b>Carcinoma, far advanced right breast &amp; metastasis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>2 mos.</b> <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Marked jaundice &amp; Hepatic metastasis</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>MAY 7 - 1967</b> to <b>MAY 19 - 1967</b> , that (II) (we) last saw the deceased alive on <b>5-19-1967</b> , and that death occurred at <b>1 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Richard Schindler</b>						M.O. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/22/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>RICHARD E. SCHINDLER</b>						22d. ADDRESS <b>69 GREENE ST., CUMB., MD., 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/22/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Catholic Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Near Cumberland, Md</b>					
24. FUNERAL DIRECTOR <b>John J. Hafer, Jr.</b>						ADDRESS <b>230 Balto Ave., Cumberland</b>		DATE <b>MAY 21 1967</b>			
25a. MARRIED BY REGISTRAR <b>John J. Hafer, Jr.</b>						25b. REGISTRAR'S SIGNATURE <b>John J. Hafer, Jr.</b>					

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ALLEGANY

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CUMBERLAND

12 DAYS

LA WALE

SACRED HEART HOSPITAL

1333 NATIONAL HIGHWAY

JOSEPHINE

C.

ALBERT

WAY

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WHITE

FEMALE

03-06-23

AB

HOUSEWIFE

WILLIAM COLE

WAY (COOPER) COLE

U.S.A.

SANDYHOOK, MARYLAND

219-12-2114

HOSPITAL RECORDS

RICHARD E. SCHINDLER

60 GREENE ST., CAMP, MD., 21020

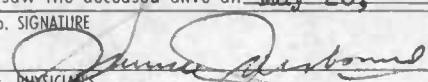
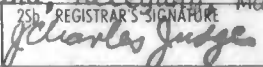


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05999

CERTIFICATE OF DEATH

05988

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS 18HRS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>HILL CREST DRIVE</b>	
3. NAME OF DECEASED (Type or print) <b>DOROTHY S. AMICK</b>		4. DATE OF DEATH <b>MAY 21, 1967</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. BIRTH DATE <b>3-28-1896</b>		9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Corporate Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bldg. &amp; Mortgage Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND, Hagerstown</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>STREET, JOHN MR.</b>		14. MOTHER'S MAIDEN NAME <b>SPICER, JESSIE MRS.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>235-30-2163</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of liver</b> <b>1 yr. Plus</b> INTERVAL BETWEEN ONSET AND DEATH DUE TO (b) <b>Adenocarcinoma right hemicolon</b> DUE TO (c) <b>1538</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 14, 1966</b> , to <b>May 21, 1967</b> , that (I) (we) last saw the deceased alive on <b>May 20, 1967</b> , and that death occurred at <b>12:15 A.M.</b> causes and on the date stated above.					
22a. SIGNATURE 		22b. DATE SIGNED <b>May 22, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. JACOBSON</b>	
22d. ADDRESS <b>50 PERSHING ST, CUMBERLAND, MD.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>5/23/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George</b>		25a. REC'D BY REGISTRAR <b>MAY 24 1967</b>		25b. REGISTRAR'S SIGNATURE 	

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05588

05588

MARYLAND

MARYLAND

MARYLAND

CUMBERLAND

2 DAYS 1985

CUMBERLAND

HILL CREST DRIVE

MEMORIAL HOSPITAL

MAY 24, 1987

WILSON

WILSON

71

3-23-1986

FEMALE WHITE

1000 E. Washington St., Baltimore, MD 21201

1000 E. Washington St., Baltimore, MD 21201

SPICER, JESSIE MRS.

STREET, JOHN MR.

MEMORIAL HOSPITAL, CUMBERLAND, MD

204-20-2133

MD

MEMORIAL HOSPITAL, CUMBERLAND, MD

MEMORIAL HOSPITAL, CUMBERLAND, MD

MAY 24, 1987

WILSON

WILSON

12:15 A.M.

MAY 24, 1987

27 BERNHARDT ST., CUMBERLAND, MD

DR. JACOBSON

CUMBERLAND, MARYLAND

CUMBERLAND, MARYLAND

CUMBERLAND

CUMBERLAND, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06000

CERTIFICATE OF DEATH

05989

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>	
c. LENGTH OF STAY IN lb <b>D. O. A.</b>		d. STREET ADDRESS <b>70 WALNUT ST.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANTHONY FRANCIS ARNONE</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>11</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 21, 1905</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE MAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOTEL</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LOUIS ARNONE</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE QUALTIRE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WW 2</b>		16. SOCIAL SECURITY NO. <b>215-05-8055</b>	
17. INFORMANT <b>MRS. JENNIE ARNONE, FROSTBURG, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>Cardiovascular disease</b> stating the underlying cause last. (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs -</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1966</b> , to <b>May 11, 1967</b> , that (I) (we) last saw the deceased alive on <b>May 10, 1967</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John B. Davis, M.D.</b>		22b. DATE SIGNED <b>5/12/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN B. DAVIS, M. D.</b>		22d. ADDRESS <b>2 BROADWAY, FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MAY 13, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAEL'S CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MD.</b>
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR <b>MAY 15 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

02922

02922

STATE OF CALIFORNIA

OFFICE OF THE

RECORDS

CLERK

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the State of California, at the City of Sacramento, this 1st day of January, 1901.

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## CERTIFICATE OF DEATH

Reg. Dist. No. **05990****06001**

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McCoole</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McCoole</b> <b>01.1</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home 16 Queen Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sarah Ann Beavers</b>			4. DATE OF DEATH Month Day Year <b>May 3, 1, 1967</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1880</b>		9. AGE (In years lost birthday) yrs. <b>87</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Herndon, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Richard Reeves</b>			14. MOTHER'S MAIDEN NAME <b>Nancy Frye</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>217-48-2512</b>		
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour many years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			20g. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to <b>5-1</b> , 19 <b>67</b> , that I last saw the deceased alive on <b>5-1-67</b> , 19____, and that death occurred at <b>8:45</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Westernport, Md. 5-3-67</b>					
ACTUAL SIGNATURE <b>William W. Lesh</b>			M.D. <b>Westernport, Md.</b>		
PHYSICIAN'S NAME (Type) <b>William W. Lesh</b>			<b>Westernport, Md.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-3-67</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas L. Lesh Jr.</b>			24a. REC'D BY REGISTRAR <b>MAY 5 1967</b>		
ADDRESS <b>Keyser, W. Va.</b>			24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Alleyway

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Home's Green Street

May 11

Ann Roberts

Robert

57

April 1, 1960

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White

Herndon, Va.

at the house of

Henry Pyle

Richard Reeves

McDonnell, Md.

517-00-0018

to

no

(cont)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06002

CERTIFICATE OF DEATH

05991

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Gilmore) R-F-D-Frostburg, Md.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARTHA E BEEMAN</b>				4. DATE OF DEATH <b>5/11/1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/21/1897</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Lonaconing, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Leo McKenzie</b>			
14. MOTHER'S MAIDEN NAME <b>Eleanor Coleman</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Charles Beeman</b> Address <b>Gilmore, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion - (Husband)</b> DUE TO (b) <b>HCVD C arteriosclerosis</b> DUE TO (c) <b>3 yrs -</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 1967</b> to <b>5/11/1967</b> that (I) <b>last</b> saw the deceased alive on <b>5/11/1967</b> , and that death occurred on <b>5/11/1967</b> M, from causes on and on the date stated above.							
22a. SIGNATURE <b>John B. Davis</b>				22b. DATE SIGNED <b>5/11/67</b>		22c. PHYSICIAN'S NAME (Type) <b>John B. Davis, M.D.</b>	
22d. ADDRESS <b>2 B Roadway Frostburg Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/15/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Josephs Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Midland, Md.</b>	
24. FUNERAL DIRECTOR <b>George Eichhorn</b>				25a. REC'D BY REGISTRAR <b>MAY 15 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06003

CERTIFICATE OF DEATH

05993

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Miner's Hospital</u>		d. STREET ADDRESS <u>New Row</u>	
3. NAME OF DECEASED (Type or print) <u>John H. Brailer</u>		4. DATE OF DEATH <u>May 24 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 31 83</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter (Carpenter)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MD Savage MD</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>George C Brailer</u>		14. MOTHER'S MAIDEN NAME <u>Emma Durbin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Clinton Brailer</u> Address <u>MD Savage</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal ilemia - due to chronic renal failure</u> DUE TO (b) <u>Arteriosclerotic Hypertensive CVD.</u> DUE TO (c) <u>20 yrs?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>✓ 19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/16</u> , 1967, to <u>5/24</u> , 1967, that (I) (we) last saw the deceased alive on <u>5/24</u> 1967, and that death occurred at <u>2:30 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Martin M. Rothstein</u> M.D.		22b. DATE SIGNED <u>5/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARTIN M. ROTHSTEIN M.D.</u>		22d. ADDRESS <u>48 BROADWAY - FROSTBURG MD. 21532</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Patricks Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>MD Savage MD</u>
24. FUNERAL DIRECTOR <u>Louis Stein Inc. - Camb. MD</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAY 29 1967</u>	

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MASSACHUSETTS  
STATE DEPARTMENT OF REVENUE  
100 STATE STREET  
BOSTON, MASSACHUSETTS 02109

MASSACHUSETTS  
STATE DEPARTMENT OF REVENUE  
100 STATE STREET  
BOSTON, MASSACHUSETTS 02109

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06004

05994

1. PLACE OF DEATH a. COUNTY <b>Allegany County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>83 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>939 Glenwood Street</b>		d. STREET ADDRESS <b>939 Glenwood Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Noah</b> Middle <b>Alfred</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1883</b>
9. AGE (in years last birthday) <b>83 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired City Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Street Dept.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Albert J. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Cooke</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-38-2360</b>	
17. INFORMANT <b>Cumberland City Police Dept.</b>		Address <b>Cumberland Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Coronary Occlusion</b> 4201 Conditions, if any, which gave rise to immediate causa (e), stating the underlying cause last. DUE TO (b) <b>Coronary Sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> --	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarellic</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarellic, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 5, 1967</b>	
22. DATE SIGNED		Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 10, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Near Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR <b>John J. Hafer, Jr.</b>		ADDRESS <b>230 Balto Ave. Cumberland Md</b>	
25a. REC'D BY REGISTRAR <b>9 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician. Page 1 is to be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaVale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaVale, MARYLAND</b>	
c. LENGTH OF STAY in 1b <b>68 years</b>		d. STREET ADDRESS <b>908 NATIONAL HIGHWAY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>908 Nat. Highway, LaVale, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LESTER</b> Middle <b>WILSON</b> Last <b>BROWNING</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>12</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY, 25, 1898</b>
9. AGE (In years and birthday) <b>68</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CARPENTER</b>	11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MARYLAND</b>
13. FATHER'S NAME <b>RUSSELL BROWNING</b>		14. MOTHER'S MAIDEN NAME <b>MRS. JULIA F. (JACKSON) BROWNING</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>214-05-6395</b>	
17. INFORMANT <b>MRS. RUTH V. BROWNING</b>		Address <b>908 NATIONAL HIGHWAY LaVale, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive Heart Disease</b> (c), stating the underlying cause last, <b>Coronary artery disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>25 yrs.</b> <b>25 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 8, 1966</b> to <b>May 12, 1967</b> that (I) (we) last saw the deceased alive on <b>May 12, 1967</b> , and that death occurred at <b>5.25 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>James P. Hallinan MD</b>		22b. DATE SIGNED <b>5-12-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. JAMES P. HALLINAN</b>		22d. ADDRESS <b>140 BEDFORD STREET, CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>15 MAY 67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>REST LAWN MEMORIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>LaVale, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bole L. Meritt</b>		25a. REC'D BY REGISTRAR <b>MAY 16 1967</b>	
ADDRESS <b>404 Decatur street CUMBERLAND, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

15 20360

0236

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
06006					CERTIFICATE OF DEATH					05996				
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY in 1b <b>19 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					01.1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>410 DECATUR ST.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>F.</b> Last <b>BUCKLEW</b>					4. DATE OF DEATH Month <b>MAY</b> Day <b>10</b> Year <b>1967</b>									
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>1-15-1876</b>		9. AGE (In years lost birthday) yrs. <b>91</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired B &amp; O R. R. Conductor</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>J. BALDWIN BUCKLEW</b>					14. MOTHER'S MAIDEN NAME <b>Rachael Rhodes</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>705-09-7801</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>				Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cordial arrest, terminal</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease with</b> DUE TO <b>longest failure</b> (c) <b>Generalized arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <b>2:30 pm</b> , 19 <b>10 May</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10 May</b> , 19 <b>67</b> , and that death occurred at <b>5:10 P.M.</b> , from causes and on the date stated above.														
22a. SIGNATURE <b>W. Alfred Van Ormer</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10 May 67</b>						
22c. PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>						22d. ADDRESS <b>CUMBERLAND, MD.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/13/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Maryland</b>							
24. FUNERAL DIRECTOR <b>H. Lee Silcox</b>						25a. REC'D BY REGISTRAR <b>MAY 15 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						

100-100000  
100-100000  
100-100000

100-100000

100-100000

ALLIANCE

MARYLAND

ALLIANCE

CHURCHMAN

10 DAYS

CHURCHMAN

MEMORIAL HOSPITAL

411 LOCUST ST.

JOSEPH

BUCKLE

NO

10

MALE WHITE

1-18-1932

21

Address: 100 N. 1st St., Baltimore, Md.

West Virginia

100 N. 1st St.

PAID BY BUCKLE

100 N. 1st St.

100-100000

100

MEMORIAL HOSPITAL, CHURCHMAN, MD.

2:10 P.M.

CHURCHMAN, MD.

DR. J. J. VAN ORDER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06007

CERTIFICATE OF DEATH

05997

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> 01.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>212 CECELIA STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>R</b> Last <b>CAMPBELL</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>18</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-9-1909</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>PHILLIP CAMPBELL</b>		14. MOTHER'S MAIDEN NAME <b>SIPPIE MOBLEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coplastic Anaemia</b> <b>292.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocarditis</b> DUE TO (c) <b>Atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mon</b> <b>6 mon</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 15, 1967</b> to <b>May 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>May 17, 1967</b> , and that death occurred at <b>5:30 A.M.</b> on <b>May 18, 1967</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Clay E. Durrett</b> M.D.		22b. DATE SIGNED <b>May 18, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>CLAY E. DURRETT, MD.</b>		22d. ADDRESS <b>236 VIRGINIA AVE., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 20, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET MEMORIAL PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND, MD.</b>	
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>		25a. BY REGISTRAR <b>MAY 22 1967</b>	
ADDRESS <b>CUMBERLAND, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

052507

CERTIFICATE OF DEATH

052507

ALLEGANY

CORPSE

MEMORIAL HOSPITAL

JAMES

WIFE

HOME

PHILIP CAMPBELL

515 DECE 15 STREET

CAMPBELL MAY 15, 1907

1-1-1000

NORTH CO. 114

STREET N. 157

12:30 A.M.

CLAY E. WILSON

206 VIRGINIA AVE., CHESAPEAKE, VA.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06008-

## CERTIFICATE OF DEATH

05998

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN TB <b>4/1/1966</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				d. STREET ADDRESS <b>Rt. #4, Box 9</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Allegany County Infirmary</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Thomas</b> Last <b>Cardor</b>				4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/20/1874</b>	
9. AGE (In years last birthday) <b>92</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired: W/Md. R.R. - Yard man</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>James Cardor</b>				14. MOTHER'S MAIDEN NAME <b>Jane Twigg</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no no</b>				16. SOCIAL SECURITY NO. <b>212-24-0949</b>		17. INFORMANT <b>P.O. Box 599, Cumberland, Md.</b> <b>Allegany County Infirmary records.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial insufficiency</b> DUE TO (b) <b>aortic aneurysm</b> DUE TO (c) <b>Chl. ASH D. with Myocardial Infuff.</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/1/66</b> , 19__, to <b>5/29/67</b> , 19__, that (I) (we) last saw the deceased alive on <b>5/29/67</b> , 19__, and that death occurred at <b>10:40 A.M.</b> from causes on and on the date stated above.							
22a. SIGNATURE <b>John A. Tepper</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5/31/1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>John A. Tepper</b>				22d. ADDRESS <b>1110 Memorial Hwy - Cumberland - Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 31, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oldtown Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Oldtown, Md. Allegany</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 5 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02232

00000

Director

Mr. Tolson

Mr. Clegg

Mr. Glavin

Mr. Ladd

Mr. Nichols

Mr. Rosen

Mr. Tracy

Mr. Carson

Mr. Egan

Mr. Gurnea

Mr. Hendon

Mr. Pennington

Mr. Quinn

Mr. Nease

Mr. Gandy

Mr. Egan

Mr. Gandy

Mr. Egan

Mr. Gandy

Mr. Egan

Mr. Gandy

Mr. Egan

Mr. Gandy

Mr. Egan

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06003

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05999

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route 1, Oldtown Road</b>		c. LENGTH OF STAY IN 1b <b>9 mos.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route 1, Oldtown Road</b>		01-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bear Hill Road</b>		d. STREET ADDRESS <b>Bear Hill Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Soren Christensen</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1889</b>
9. AGE (In years lost birthday) yrs. <b>77</b>		10. IF UNDER 1 YEAR Months <b>16</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Standard Oil Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Denmark</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Ann B. Bishop, Route 1, Oldtown, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>----</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarlic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarlic, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> May 16, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 18, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md. Allegany</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 18 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Orlando Judge</b>			

02530

02530

*James M. Johnston*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06010

CERTIFICATE OF DEATH

06000

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>9/29/64</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaVale</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Allegany County Infirmary</b>		d. STREET ADDRESS <b>11 N. Woodlawn Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth R. Glose</b>		4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>19 67</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/22/1885</b>	
9. AGE (In years) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired: Stenographer &amp; Sitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baby</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Eckhart Mines, Frostburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alexander Glose</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ferguson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>P.O. Box 599,</b> Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary records.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Insufficiency</b> DUE TO (b) <b>Parkinson Disease</b> DUE TO (c) <b>chr. ASH-D with Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>15 yrs</b> <b>15 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/29/64</b> , 19__, to <b>5/30/67</b> , 19__, that (I) (we) last saw the deceased alive on <b>5/29/67</b> , 19__, and that death occurred at <b>A.</b> M., from causes and on the date stated above.			
22a. SIGNATURE <b>John A. Pepper</b>		22b. DATE SIGNED <b>5/31/1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>John A. Pepper, MD</b>		22d. ADDRESS <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-1-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Eckhart</b>		23d. LOCATION (City or Town) (County) (State) <b>Eckhart, Allegany, Md.</b>	
24. FUNERAL DIRECTOR <b>Joseph R. Durd, Frostburg, Md.</b>		25a. REC'D BY REGISTRAR <b>J. Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		DATE <b>JUN 2 1967</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06011

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06001

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>75-3</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Annie Coffman</b>		d. STREET ADDRESS <b>2130 E. 42nd. Street</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 18, 1894</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>1967</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Hunter</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ramsey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Edward Adams</b>		Address <b>Cumb. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>---</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		22. DATE SIGNED <b>May 2, 1967</b>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 2, 1967</b> Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/5/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lakeside Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Erre, Penna (Erre Co)</b>	
24. FUNERAL DIRECTOR <b>Louis Stein Inc. Cumb. Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 4 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

05084

05084

James H. Hester

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06012

CERTIFICATE OF DEATH

06002

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN lb <b>6 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS HOSPITAL</b>		e. STREET ADDRESS <b>242 LOWER CONSOLIDATION</b>	
3. NAME OF DECEASED (Type or print) <b>MILLIE F. COSGROVE</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>3</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 26, 1900</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BENJAMIN FILER</b>		14. MOTHER'S MAIDEN NAME <b>RACHEL FOLK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-01-3683-A</b>	
17. INFORMANT <b>MRS. ROBT. BARR, FROSTBURG, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the Uterus - Pelvic</b> 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>NONE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 1966</b> to <b>5/3, 1967</b> that (I) (we) last saw the deceased alive on <b>5/3, 1967</b> , and that death occurred at <b>8:45 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Martin Rothstein</b>		22b. DATE SIGNED <b>5/4/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>MARTIN ROTHSTEIN, M. D.</b>		22d. ADDRESS <b>48 BROADWAY, FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MAY 5, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FBG. MEMORIAL PARK</b>	23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MD.</b>
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, FROSTBURG, MD.</b>		25. REC'D BY REGISTRAR <b>MAY 8 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06013

CERTIFICATE OF DEATH

07455

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN Ib <b>4/11/1967</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		d. STREET ADDRESS <b>420 Holland Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thomas Bernard Cumiskey Jr.</b>		4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/10/1884</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired: Columbia Gas Company</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Cumiskey</b>		14. MOTHER'S MAIDEN NAME <b>Mary Rhodes Cumiskey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>P.O. Box 599, Cumberland, Maryland</b>		<b>Allegany County Infirmary records.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Acute Coronary Insufficiency</b> DUE TO (b) <b>Chc. Prostatic Hypertrophy with Prostatic Hypertrophy</b> DUE TO (c) <b>Chc. A.D.H.D. with Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>approx. 10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>A.S. Chronic Brain Syndrome. Aortic Stenosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 11, 1967</b> , to <b>May 5, 1967</b> , that (I) (we) last saw the deceased alive on <b>May 5, 1967</b> , and that death occurred at <b>8:55 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John A. Topper</b>		22b. DATE SIGNED <b>May 6 - 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>John A. Topper</b>		22d. ADDRESS <b>Hyndman, Pa.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/9/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Md</b>	
24. FUNERAL DIRECTOR <b>Louis Stein Inc. Camb. Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 9 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any dissection is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your use. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>W.Va.</b>		b. COUNTY <b>Hampshire</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>1 Hour</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Augusta</b>		d. STREET ADDRESS <b>553</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Blake Davis</b>		First Middle Last		4. DATE OF DEATH <b>May 4 1967</b>		Month Day Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-2-50</b>	
9. AGE (In years last birthday) <b>17 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Frank Davis</b>		14. MOTHER'S MAIDEN NAME <b>Pauline Corbin</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>Mrs Frank Davis</b>		Address <b>Augusta, West Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Shock</b> <b>8240</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Extensive Body Burns (98%)</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 Hours</b> <b>2 Hours</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Driver of truck which overturned and caught fire</b>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of truck which overturned and caught fire</b>					
20c. TIME OF INJURY Month, Day, Year <b>12:50 p.m. May 4 1967</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Junction Rt. 50 &amp; 220 Near Keyser, W.Va.</b>		20f. (City or town) (County) (State) <b>W.Va.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>May 4, 1967</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/7/67</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Tearcoat Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Augusta, Hampshire W Va.</b>	
23. FUNERAL DIRECTOR <b>Wade H. McKee</b>		ADDRESS <b>Augusta, W Va.</b>		24a. REC'D BY REGISTRAR <b>MAY 10 1967</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

03003

03003

MAY 10 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06015

CERTIFICATE OF DEATH

06004

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MOOREFIELD, W. VA.</b>		85.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>311 ELM STREET</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARION</b> Middle <b>H.</b> Last <b>DEAHL</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>14</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-10-1901</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>DAVIS, W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CALVIN J. DEAHL</b>		14. MOTHER'S MAIDEN NAME <b>SARAH HUFFMAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage with L. hemiplegia, etc.</b> DUE TO <b>Basal artery insufficiency</b> DUE TO <b>A.S. Cardiovascular disease with Htn. A.S.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>2 months +</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Macrocytic anemia 5 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10 May 1967</b> , to <b>14 May 1967</b> , that (I) (we) last saw the deceased alive on <b>13 May 1967</b> , and that death occurred at <b>3:55 AM</b> , <b>Moorefield</b> and on the date stated above.			
22a. SIGNATURE <b>W. Alfred Van Ormer</b> M.D.		22b. DATE SIGNED <b>14 May 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. A. VAN ORMER</b>		22d. ADDRESS <b>122 SO. CENTRE ST. CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 17, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Moorefield, West Virginia</b>	
24. FUNERAL DIRECTOR <b>Thrush Funeral Home, Moorefield, West Virginia</b>		25a. REC'D BY REGISTRAR <b>MAY 25 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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MEMORIAL HOSPITAL

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HARRIS

DEATH

DATE WHITE

12-10-1907

CAVIN J. DEAN

SARAH MURRAY

RETIRED COLLECTOR

DAVIS, W. VA.

NEW HALL HOSPITAL, CHURCHLAND, MO.

W. A. VAN ORDER

1225 SO. CENTRE ST. CHURCHLAND, MO.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**06016**

**CERTIFICATE OF DEATH**

**06005**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>19 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>BOX 229 RT. #2, FROSTBURG</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>DURWARD</b> Middle <b>DEFFENBAUGH</b> Last <b>DEFFENBAUGH</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>7</b> Year <b>19 67</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-19-1903</b>		9. AGE (In years lost birthday) <b>63 yrs.</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>KELLY TIRE CO.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE DEFFENBAUGH</b>				14. MOTHER'S MAIDEN NAME <b>KATHRYN DICKEN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-01-1575</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma bone</b> DUE TO <b>Bronchogenic Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lungs</b> <b>Pathological fracture Neck, Left femur, Uremia, Metastatic Disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/1/67</b> , 19 <b>67</b> , to <b>5/7/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>May 7,</b> 19 <b>67</b> , and that death occurred at <b>11:55 A.M.</b> on <b>May 7,</b> 19 <b>67</b> , and on the date stated above.							
22a. SIGNATURE <i>Samuel Jacobson</i>				22b. DATE SIGNED <b>5/8/67</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. S.M. JACOBSON</b>	
22d. ADDRESS <b>50 PERSHING STREET, CUMBERLAND, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 10, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG MARYLAND</b>	
24. FUNERAL DIRECTOR <b>MARYLOU M. SOWERS</b>				25a. REC'D BY REGISTRAR <b>11 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
26. ADDRESS <b>60 W. MAIN, FROSTBURG</b>							

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ALLIED

CUMBERLAND

MEMORIAL HOSPITAL

DEPARTMENT

MALE WHITE

RETIRED

GEORGE OFFENBACH

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ST. W. FROSTBURG

OFFENBACH

MAY

8-12-1903

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EMILY T. CO.

FROSTBURG, MD.

KATHRYN D. CO.

217-01-5555 MEMORIAL HOSPITAL, CUMBERLAND, MD.

For this diagnosis

reference to the

11:17 A.M.

DR. J. M. JACOBSON

33 PERSHING STREET, CUMBERLAND,

DR. J. M. JACOBSON

DR. J. M. JACOBSON

DR. J. M. JACOBSON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06017

06006

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>Lonaconing</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital</b>		d. STREET ADDRESS <b>State Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>L.</b> Last <b>Elkins</b>		4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/8/1904</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>29</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Keyser, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Elkins</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Gay</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Gladys Elkins</b>		Address <b>Lonaconing, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> DUE TO (b) <b>Coronary Insufficiency</b> DUE TO (c) <b>Arteriosclerosis - generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr. 1 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uncontrolled diabetes mellitus - acidosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 29, 1967</b> to <b>May 29, 1967</b> , that (I) (we) last saw the deceased alive on <b>May 29, 1967</b> , and that death occurred at <b>2 p.m.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>L. R. Miles, Jr.</b>		22b. DATE SIGNED <b>5-29-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. R. MILES, JR., M.D.</b>		22d. ADDRESS <b>LONA CONING MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/1/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Lonaconing A. Md</b>	
24. FUNERAL DIRECTOR <b>George Eichhorn</b>		25a. REC'D BY REGISTRAR <b>MAY 31 1967</b>	
ADDRESS <b>Lonaconing, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06007

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>PENNA.</b> b. COUNTY <b>SOMERSET</b> <del>DELFORD</del>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYNDMAN, PA.</b>	
		d. STREET ADDRESS <b>RD#1</b>	
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>B</b> Last <b>EMERICK</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>28</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-14-77</b>
9. AGE (In years last birthday) yrs. <b>89</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>HYNDMAN, PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN L. EMERICK</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH BONELL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-40-2879</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4500 Acute Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Advanced pulmonary emphysema</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 1964</b> to <b>May 28, 1967</b> , that (I) (we) last saw the deceased alive on <b>5-28 1967</b> , and that death occurred at <b>11:35A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>William P. James</b>		22b. DATE SIGNED <b>5/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. P. JAMES</b>		22d. ADDRESS <b>CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>May 31, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Comps Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hyndman, Somerset Co., Pa. RD#1</b>
24. FUNERAL DIRECTOR <b>Harvey H. Feigler</b>		25a. REC'D BY REGISTRAR <b>JUN 5 1967</b>	
ADDRESS <b>Hyndman, Pennsylvania</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06013

Item #9 Film 4357-5/23/57

## CERTIFICATE OF DEATH

06008

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
c. LENGTH OF STAY IN 1b <b>16 DAYS</b>				d. STREET ADDRESS <b>507 PRINCE GEORGE STREET</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN J. FOLEY</b>		First Middle Last		4. DATE OF DEATH <b>MAY 14 19 67</b>		Month Day Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07-27-92</b>	9. AGE (In years last birthday) <b>74 7/8 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLANT SUPERVISER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CELANESE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WESTERNPORT, MD. ALLEGANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM Foley</b>				14. MOTHER'S MAIDEN NAME <b>ELLEN (HOBAN)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-10-4980</b>		17. INFORMANT <b>PATIENTS HOSP RECORD SHH</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL FAILURE</b> <b>4200</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>PULMONARY EMBOLISM-BRONCHITIS-EMPHYSEMA</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS.</b> <b>20 YRS.</b> <b>5 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>PERFORATED DUODENAL ULCER WITH PERTONITIS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>NONE</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>NONE</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>APRIL 29, 19 67</b> , to <b>MAY 14, 19 67</b> , that (I) (we) last saw the deceased alive on <b>MAY 14, 19 67</b> , and that death occurred at <b>5:10 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>James F. Scarpelli</i>				22b. DATE SIGNED <b>5-15-67</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. HALLINAN</b>	
22d. ADDRESS <b>140 BEDFORD STREET, CUMBERLAND, MD.</b>				22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>May 16, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md. Allegany</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 17 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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12 DAYS

CUTLERLAND

507 PRICE BEAR STREET

SACRED HEART HOSPITAL

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J.

JOHN

WHITE

WILE

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07-27-32

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U.S.A.

WESTERNPORT, W. ALLEGANY

CELESTINE

PLANT SUPERVISOR

ELLEN (HODG)

WILLIAM

SHI

PATIENTS HOSP RECORD

217-13-4000

10

MYOCARDIAL FAILURE

ARTERIOSCLEROTIC HEART DISEASE

PULMONARY EMPHYSEMA-BRONCHITIS-EMPHYSEMA

PERFORATED GASTRIC ULCER WITH PERITONITIS

NONE

NONE

APRIL 22

2:10 PM

67

MAY 10

8-12-32

120 BEDFORD STREET, CUNBERLAND, MD.

DR. HALLMAN

MAY 12 1932



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b>					c. LENGTH OF STAY IN 1b <b>13 DAYS</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HSOPITAL</b>					e. STREET ADDRESS <b>FROSTBURG, 95 BRADDOCK STREET FROSTBURG, MARYLAND 21532</b>						
3. NAME OF DECEASED (Type or print) <b>ETHA P. FULLER</b>					4. DATE OF DEATH Month <b>MAY</b> Day <b>6</b> Year <b>1967</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-9-1894</b>		9. AGE (In years last birthday) <b>73 yrs.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>LAUREL DALE, W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>WILLIAM H. WALLBOTT</b>					14. MOTHER'S MAIDEN NAME <b>SYNTHY (BURGESS) WALLBOTT</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>					16. SOCIAL SECURITY NO. <b>217-05-7655</b>		17. INFORMANT <b>HOSP. RECORD</b>			Address <b>SACRED HEART HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive coronary occlusion</b> 4201 DUE TO (b) <b>Anteroseptal C. V. D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Surgery May 1, 1967 - cholecystectomy &amp; umbilical hernia repair</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>4/23</b> , 19 <b>67</b> , to <b>5/6</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>5/5</b> , 19 <b>67</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Thomas F. Lewis</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/6/67</b>				
22c. PHYSICIAN'S NAME (Type) <b>DR. T. LEWIS</b>					22d. ADDRESS <b>500 GREEN ST. CUMBERLAND MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>MAY 8 '67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F.B.G. MEMORIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>				
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>					25a. REC'D BY REGISTRAR <b>MAY 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

200 GREEN ST. CUMBERLAND, MD.

DR. T. LEWIS

ALLEBANY

HARVARD

ALLEBANY

FROSTING, 25 BRADDOCK STREET  
FROSTING, HARVARD 21532

13 DAYS

CUMBERLAND, MD.

SACRED HEART HOSPITAL

FULLER MAY

P. X

FEMALE WHITE

2-2-1 # 73

HOSPITAL

LAUREL DALE, W.VA. U.S.A.

SYNTH (URGESS) WALLBOTT

WILLIAM H. WALLBOTT

217-02-7-52 HOSP. RECORD SACRED HEART HOSPITAL

NO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06021

CERTIFICATE OF DEATH

06010

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>6 DAY 9 HR</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>FULTON</b> Last <b>FULTON</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>10</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-30-1882</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	11. BIRTHPLACE (County & State, or foreign country) <b>BROADTOP, PENNA.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>IRVIN FULTON</b>	
14. MOTHER'S MAIDEN NAME <b>BRIGID LAVELLE</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>216-22-6298</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Upper Respiratory Infection</b> DUE TO <b>Probable Granulomatous Disease</b> DUE TO <b>Myocarditis &amp; Decomposition</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>7</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 7, 1967</b> , to <b>May 10, 1967</b> , that (I) (we) last saw the deceased alive on <b>May 10, 1967</b> , and that death occurred at <b>11:25 P.M.</b> by <b>Myself</b> and on the date stated above.			
22a. SIGNATURE <b>Clay E. Durrett</b>		22b. DATE SIGNED <b>MAY 13, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>CLAY E. DURRETT</b>		22d. ADDRESS <b>236 VIRGINIA AVE., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 13, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland Md. Allegany</b>
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 17 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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CHURCH AND

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CHURCH AND

MEMORIAL HOSPITAL

513 VIRGINIA AVENUE

JOHN

JOHN

MAY 10

1982-10-10

WILEY WHITE

RETIRED

RETIRED

JOHN FULTON

BRIGGS FULTON

MEMORIAL HOSPITAL, CHURCH AND, MD.

CLAY E. DURETT

513 VIRGINIA AVE., CHURCH AND, MD.

11:00 P.M.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06022

CERTIFICATE OF DEATH

06011

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>		c. LENGTH OF STAY IN 1b <b>70 Yrs</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>115 Spruce St.</b>			d. STREET ADDRESS <b>115 Spruce</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Lawrence</b> Middle <b>Elmer</b> Last <b>Gales</b>			4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16m 1890</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Paper Mill</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Mineral-W. Va.</b>	
13. FATHER'S NAME <b>George W. Gales</b>			14. MOTHER'S MAIDEN NAME <b>Addie Whithair</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>Yes W.W. I</b>		16. SOCIAL SECURITY NO. <b>212-12-8492</b>		17. INFORMANT <b>Angie Gales Burgess-Westernport, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443 X Chronic Myocarditis with Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Chronic Bronchitis with Asthma</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 Years</b> <b>20 Years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 4, 1963</b> to <b>May 15, 1967</b> that (I) (we) last saw the deceased alive on <b>May 14 1967</b> , and that death occurred at <b>5:30 AM</b> , from causes on and on the date stated above.					
22a. SIGNATURE <b>Paul R. Wilson</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>May 15, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Paul R. Wilson</b>		22d. ADDRESS <b>Piedmont, W. Va.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/17/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>		23d. LOCATION (City or Town) (County) (State) <b>Westernport Md.</b>	
24. FUNERAL DIRECTOR <b>E. L. Boal</b>		ADDRESS <b>Westernport, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 18 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF NEW YORK

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06023

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06012

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>69 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>19 Boone Street</b>			d. STREET ADDRESS <b>19 Boone Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sarah (Sadie) Hansrote</b>			4. DATE OF DEATH Month Day Year <b>May 19 19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1897</b>	9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Emanuel Beal</b>		
14. MOTHER'S MAIDEN NAME <b>Sarah Beal</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Mr. Wilbur Hansrote, Cumberland, Md. Son</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>CORONARY SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>----</b> (c) <b>----</b>					INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Cumberland, Md.</b>		22. DATE SIGNED <b>May 19, 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 22, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town)	(County)	(State) <b>Allegany</b>
24. FUNERAL DIRECTOR <b>James T. Scarpelli, Cumberland, Md.</b>			25a. REC'D BY REGISTRAR <b>MAY 23 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06024

CERTIFICATE OF DEATH

06013

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>WEST VIRGINIA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>11 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PETERSBURG, WEST VIRGINIA</b>		d. STREET ADDRESS <b>9 NORTH MAIN ST.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MIMA</b> Middle <b>P</b> Last <b>HARPER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>29</b> Year <b>19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-2-92</b>
9. AGE (In years lost birthday) yrs. <b>75</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>TRUMAN PARSON</b>		14. MOTHER'S MAIDEN NAME <b>VIRGINIA HYRE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4500 Uremia - Arterio sclerotic</b> DUE TO (b) <b>Vascular disease for advanced</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Osteo arthritis - joints of fingers &amp; large</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>jam's</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5. 18. 67</b> to <b>5. 29. 1967</b> that (I) (we) last saw the deceased alive on <b>5. 28. 1967</b> , and that death occurred at <b>6:15 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Wm. F. Williams M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>		22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>May 31 - 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Maple Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Petersburg - Grant W. Va.</b>	
24. FUNERAL DIRECTOR <b>William B. Knight - Cumberland Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 2 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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ALLEGANY

CHURCHILL

11 DAYS

WEST VIRGINIA

0 NORTH MAIN ST.

BEVILL WHITE K 5-3-02

WEST VIRGINIA

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TRUMAN PARSON

WEST VIRGINIA

CHURCHILL

*[Faint, illegible handwritten text and signatures covering the bottom half of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <b>PENN.</b> b. COUNTY <b>MARYLAND Somerset ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY in 1b <b>48 MINUTES</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND Rockwood 75.3</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>673 Main Street 125 GRAND AVENUE</b>				
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>GIRL</b> Last <b>HELM</b>					4. DATE OF DEATH Month <b>MAY</b> Day <b>12</b> Year <b>1967</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 12, 1967</b>		9. AGE (In years lost birthday) yrs. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>DONALD E. HELM</b>					14. MOTHER'S MAIDEN NAME <b>LINDA L. PHILLIPPI</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>premature labor - 5 1/2 Mon.</b> (c) <b>4 3 min</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>197-20</b> A.M., 19 <b>—</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>7:20</b> M, from causes and on the date stated above.									
22a. SIGNATURE <b>W. Royce Hodges</b>					22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) <b>DR. W. ROYCE HODGES</b>	
22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 13, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Memorial Park, Near La Vale, Md. All.</b>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>MAY 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06026

CERTIFICATE OF DEATH

06015

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>224 HARRISON ST.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BERTIE</b> Middle <b>M.</b> Last <b>HELMICK</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>11</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-1-1897</b>
9. AGE (In years lost birthday) yrs. <b>70</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>LOST RIVER, WVA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>SIMON RIGGLEMAN</b>		14. MOTHER'S MAIDEN NAME <b>LOUISE WHETZEL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-30-2318D</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X</b> DUE TO <b>Coronary Artery Disease</b> (b) <b>Myocardial Infarction</b> DUE TO <b>Ischemic Heart Disease</b> (c) <b>Diabetes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>See above</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cumberland, Md.</b>		20f. (City or town) (County) (State) <b>Cumberland, Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>5/7/67</b> , 19 <b>67</b> at <b>7:05 P.M.</b> , that (I) (we) last saw the deceased alive on <b>5/11/67</b> , 19 <b>67</b> , and that death occurred at <b>7:05 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>DR. R. J. WILLIAMS</b>		22b. DATE SIGNED <b>5/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>		22d. ADDRESS <b>CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/14/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Biertown Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rawlings Allegany Maryland</b>	
24. FUNERAL DIRECTOR <b>H. Lee Silcox</b>		25a. REC'D BY REGISTRAR <b>MAY 16 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

00012

STATEMENT OF DEATH

00020

ALLEGANY

WARTLAND

ALLEGANY

CUMBERLAND

A DAYS

CUMBERLAND

224 HARRISON ST.

MEMORIAL HOSPITAL

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WAY

HELVICK

M.

BERTIE

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1-1-1907

X

WHITE

MALE

W. S. A.

LOST RIVER, WVA.

AT HOME

UNKNOWN

LOUISE WHITTEL

WILLIAM CIGELMAN

MEMORIAL HOSPITAL, CUMBERLAND, MD.

2:00 P.M.

CUMBERLAND, MD.

DR. R. J. WILLIAMS

and long life expectancy

and long life expectancy

and long life expectancy

and long life expectancy

and long life expectancy

and long life expectancy

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VR A15 (4)  
20 M 1/66

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06027

CERTIFICATE OF DEATH

06016

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>4/23/1965</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaVale,</b>		d. STREET ADDRESS <b>30 McKenzie Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Earl Robert Herrell</b>		4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/27/1902</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED: Celanese (Spinning Dept.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Largent, W. Va.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown,</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Herrell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-10-6980</b>	
17. INFORMANT <b>P.O. Box 599, Cumberland, Md.</b>		18. <b>Allegany County Infirmary records.</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Generalized Atherosclerosis</b> DUE TO (c) <b>Parkinson's Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>yes</b> <b>yes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/23/1965</b> to <b>5/17/1967</b> , that (I) (we) last saw the deceased alive on <b>5/16/1967</b> , and that death occurred at <b>A. M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>George M. Simons</b>		22b. DATE SIGNED <b>5/17/1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>George M. Simons, M. D.</b>		22d. ADDRESS <b>Memorial Hosp. Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/19/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany Md.</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George Cumberland, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 22 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Allegany

Barryland

Allegany



W. S. V. 1962

Chamberland

Allegheny County Jail

Roberts Her-Off

Earl

W. S. V. 1962

Allegheny County Jail

W. S. V. 1962

Allegheny County Jail

Doc. Her-Off

Allegheny County Jail

Allegheny County Jail

W. S. V. 1962

W. S. V. 1962

W. S. V. 1962

W. S. V. 1962

W. S. V. 1962

Allegheny County Jail

Allegheny County Jail

Allegheny County Jail

W. S. V. 1962

Allegheny County Jail

Allegheny County Jail

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06028

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06017

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>50 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>607 Sedgewick Street</b>		d. STREET ADDRESS <b>607 Sedgewick Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Z.</b> Last <b>Heskett</b>		4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 12, 1892</b>
9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months <b>01</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Mill Creek, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Landon C. Heskett</b>		14. MOTHER'S MAIDEN NAME <b>Clara Mae</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes War I</b>		16. SOCIAL SECURITY NO. <b>220-07-6740</b>	
17. INFORMANT <b>Miss Helen Tasker, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>---</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		22. DATE SIGNED <b>May 5, 1967</b>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 8, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Westernport, Md. Allegany</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 11 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

06023

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06018

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland Md.</b>		c. LENGTH OF STAY IN lb <b>24 Hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Herbert</b> First Middle Last <b>Huston Jewell</b>		4. DATE OF DEATH <b>May 25</b> Day Month Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1904 July 22, 1904</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boilermaker and</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Welder, Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Strasburg, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Toliver Jewell</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ellen Higgs</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Vera Louise Jewell</b>		Address <b>537 Maryland St LaVale</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Coronary Sclerosis with Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S SIGNATURE <b>Benedict Skitarelic</b> M.D. NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		22. DATE SIGNED <b>May 25, 1967</b> Address (Street, city, town, or county) <b>Cumberland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-28-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Memorial Garden</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli</b>		25a. REC'D BY REGISTRAR <b>MAY 31 1967</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1030

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*Robert H. H. H.*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any death is necessary. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

06030

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06019

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland Md.</b>		c. LENGTH OF STAY IN 1b <b>Memorial Hospital D O A.</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>New York</b> f. COUNTY <b>New York</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New York</b> d. STREET ADDRESS <b>8100 Shore Front Parkway Rockway Beach Ny.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ben</b>		4. DATE OF DEATH <b>May 11 1967</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>July 30, 1897</b>		9. AGE (In years last birthday) <b>69</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ajax Springs Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>	
13. FATHER'S NAME <b>Edward A. Kantner</b>		14. MOTHER'S MAIDEN NAME <b>Mirian Friedland</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>070-28-2498</b>		17. INFORMANT <b>Mrs. Ben Kantner</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>X <del>Coronary</del> SCLEROSIS</b> (c) <b>CORONARY SCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1201</b>		INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Cumberland, Maryland</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 11, 1967</b>		DATE SIGNED	
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D.		EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		Address (Street, city, town, or county) <b>Cumberland, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/14/67</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Ararat Cem.</b>		22d. LOCATION (City, town, or country) <b>Farmington Long Island</b>		(State)	
23. FUNERAL DIRECTOR <b>Lewis Stein Inc.</b>		ADDRESS <b>Cumb. Md</b>		24a. RECEIVED BY REGISTRAR <b>MAY 12 1967</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

05020

11-11-11

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...A. C. A. ...

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White male

Alex Springs Hotel

revised A. Brown

Unknown

Mr. Ben Kanter

RENTAL COMPANY - 2000

• **Wash** your hands before and after handling the patient.

Kantner

1974 30 1895

110/111

10-11-1947

A. B. U.

X MAY 11, 1967

Quebec, New York

RECEIVED

Received of Mr. [illegible] the sum of [illegible]

John Allen Esq

4 1

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06031

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06020

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>			d. STREET ADDRESS <b>806 Columbia Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Gladys</b> Middle <b>M</b> Last <b>Kegg</b>			4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>1967</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 15, 1914</b>	9. AGE (In years last birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cumberland Maryland</b>	
13. FATHER'S NAME <b>Frank Porter</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <b>No</b>			14. MOTHER'S MAIDEN NAME <b>Lilly Rice</b>		
16. SOCIAL SECURITY NO. <b>—</b>			17. INFORMANT <b>Edgar Kegg</b> Address <b>806 Columbia Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Tamponade</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ruptured Posterior Myocardium</b> DUE TO (c) <b>Coronary Thrombosis, Right</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 15, 1967</b>	
Address (Street, city, town, or county) <b>Cumberland, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 18, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cem.</b>	23d. LOCATION (City or Town) <b>Cumberland</b>	(County) <b>Allegany</b>	(State) <b>Md.</b>
24. FUNERAL DIRECTOR <b>James Stern Inc. Cumb. Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 19 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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Document 100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

06032

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06021

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>17 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b> COUNTY <b>ALLEGANY</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>194 CENTER STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>LORETTA</b>		First <b>M.</b>		Middle <b>KENNEY</b>		Last <b>MAY</b>		4. DATE OF DEATH Month <b>20</b> Year <b>19 67</b>															
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>04-07-88</b>		9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMRESS (RETIRED)</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BARTON, ALLEGANY, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JAMES</b>		14. MOTHER'S MAIDEN NAME <b>ANNA (MC GREEVY)</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-05-4426</b>		17. INFORMANT <b>PATIENTS HOSP. RECORD</b>		Address <b>SACRED HEART</b>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Failure</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Chronic Congestive Failure</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Emphysema</b>												INTERVAL BETWEEN ONSET AND DEATH <b>?</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from <b>5/3</b> , 19 <b>67</b> , to <b>5/20</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>5/19</b> , 19 <b>67</b> , and that death occurred at <b>6:15</b> AM, from the causes and on the date stated above.												22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>5/20/67</b>									
22c. PHYSICIAN'S NAME (Type) <b>DR. PAGAN</b>		22d. ADDRESS <b>5 POTOMAC STREET, RIDGELEY, W. VA.</b>		22e. MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/23/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Chn</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Md.</b>																	
24. FUNERAL DIRECTOR <b>Louis Stein Inc. Cumb. Md.</b>		25a. REC'D BY REGISTRAR <b>[Signature]</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c. DATE <b>MAY 23 1967</b>																	

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ALLIANCE

ALLIANCE

ALLIANCE

CONVENTION

CONVENTION

CONVENTION

104 CENTER STREET

20000 HEART HOSPITAL

CHIEF

LOVETT

WHITE

SEMPRESS (ASTOR)

(NO BODY)

WHITE

21-07-452 RIT 1125 102R RECORD SUGAR 102R

1 POTONG STREET, W. 102R

102R

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06033

CERTIFICATE OF DEATH

06022

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>BERKLEY</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>15 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PAW PAW, W. VA.</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FLOYD</b> Middle <b>L</b> Last <b>KIFER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>10</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-23-89</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>KIPER, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAVID KIFER</b>		14. MOTHER'S MAIDEN NAME <b>AMANDA ASHKETTLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>236 20 9355</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Sclerotic Vascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Cumberland City, Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>5/12/67</b> to <b>5/12/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>5/12/67</b> , 19 <b>67</b> , and that death occurred at <b>7:00A</b> M, from causes and on the date stated above.		22a. SIGNATURE <b>DR. R. J. WILLIAMS</b>	
22b. DATE SIGNED <b>5/12/67</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>	
22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>5/13/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Union Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Slanesville W. Va.</b>	
24. FUNERAL DIRECTOR <b>Johnson</b>		25a. REC'D BY REGISTRAR <b>MAY 16 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S SIGNATURE	

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00033

WEST VIRGINIA

WEST VIRGINIA

12 DAYS

12 DAYS

12 DAYS

MEMORIAL HOSPITAL

FLOYD

KIRK

MAY

WHITE

WHITE

DAVID KIRK

KIRK, W.

ASHES, ASHES

MEMORIAL HOSPITAL, C. B. ELLIOTT, MD.

00033

DR. S. J. WILLIAMS

100 S. WHITE ST., CHICAGO, ILL.

15/12/1917

15/12/1917

MEMORIAL HOSPITAL, C. B. ELLIOTT, MD.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06034

CERTIFICATE OF DEATH

06023

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN lb <b>24 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BARTON</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>145 BROADWAY ST.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MAUDE</b> Middle <b>C.</b> Last <b>KIRK</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>22</b> , Year <b>1967</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-27-1890</b>	
9. AGE (In years lost birthday) yrs. <b>77</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <b>BARTON, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>BARTON, MD.</b>	
13. FATHER'S NAME <b>WILLIAM RUSSELL</b>				14. MOTHER'S MAIDEN NAME <b>JANET C. HERON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>446X</b> DUE TO <b>NEPHROSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ARTERIOSCLEROSIS + HYPERTENSION</b> (c) <b>10 yr</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/28 67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>5/21 1967</b> , and that death occurred at <b>9:00 A.M.</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				22b. DATE SIGNED <b>5/22/67</b>		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>				22e. ADDRESS <b>59 GREENE ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/25/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>		23d. LOCATION (City or Town) (County) (State) <b>Moscow Mills Md.</b>	
24. FUNERAL DIRECTOR <b>[Signature]</b>				25a. REC'D BY REGISTRAR <b>MAY 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ALLEGANY

CHERRYLAND

MEMORIAL HOSPITAL

HAUBE

FEARLESS WHITE

EDWARD 226

WILLIAM RUSSELL

110 BROADWAY ST.

KIRK

9-7-1930

BLANK, MD.

110 BROADWAY ST.

HOSPITAL - CHERRYLAND, MD.

DR. S. L. WILSON

110 BROADWAY ST., CHERRYLAND, MD.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06035

Item #8 Film #G388 5/18/67 pc  
Item #2c & d Film #G388 5/19/67 pc

CERTIFICATE OF DEATH

06024

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>SYLVAN RETREAT</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>56 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL 900 SETON DRIVE</b>		d. STREET ADDRESS <b>119 Washington St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LOUIS NM LABER</b>		4. DATE OF DEATH 5-2-67 Month Day Year <b>19</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>21</b> <b>XXXXXX 7-12-83</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>XXXXXX</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life or last (retired)) <b>LABORER WESTERN MD. RR.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>RED HILL, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN LABER</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET GLOTHAR</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-10-2095</b>	
17. INFORMANT <b>MRS. LEWIS DEVORE, WESTERNPORT, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia + Congestive Heart Failure</b> DUE TO (b) <b>Prostate hypertrophy + obstruction +</b> DUE TO (c) <b>renal + bladder infection</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-9</b> , 19 <b>67</b> , to <b>5-2-</b> , 19 <b>67</b> that (I) (we) lost saw the deceased alive on <b>5-2</b> , 19 <b>67</b> , and that death occurred at <b>7:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Wm. A. Deemer, Jr. M.D.</b>		22b. DATE SIGNED <b>5-3-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DEEMER, JR. M.D.</b>		22d. ADDRESS <b>416 NORTH MECHANIC STREET, CUMBERLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-4-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>F.B.G. MEMORIAL PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR.,</b>		25a. REC'D BY REGISTRAR <b>MAY 8 1967</b>	
ADDRESS <b>FROSTBURG, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10034

10034

ALLEGANY

WESTERN

SPECIAL REPORT HOSPITAL AND CLINICAL

WHITE

1. LIND

RED HILL, W.V.

INTERVIEW (MAY 1951)

WEST VIRGINIA

MAY 8 1951

ALLEGANY, W.V.

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06036

06025

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> c. LENGTH OF STAY IN 1b <b>14 HRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ECKHART</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH (HARRIS) LARGENT</b> First Middle Last		4. DATE OF DEATH <b>MAY 13, 1967</b> Month Day Year	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 14, 1888</b> 9. AGE (In years last birthday) <b>79</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED COOK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>	11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>WILLIAM HARRIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>212-24-0309</b>	
17. INFORMANT Address <b>MRS. BETTY CARTER, ECKHART, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure - Rt Side</b> DUE TO <b>ASCVD.</b> (b) (c) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1967</b> to <b>May 13, 1967</b> , that (I) (we) last saw the deceased alive on <b>May 13, 1967</b> , and that death occurred at <b>9:41</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>John B. Davis, M.D.</b>		22b. DATE SIGNED <b>5/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN B. DAVIS, M. D.</b>		22d. ADDRESS <b>2 BROADWAY, FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MAY 16 '67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FBG. MEMORIAL PARK</b>	23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>
24. FUNERAL DIRECTOR ADDRESS <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR <b>MAY 18 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>

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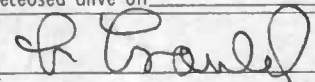
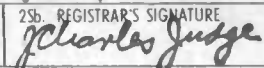
10.00

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

**06026**

**06037**

1. <b>PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> MARYLAND		2. <b>USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>9 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIDGELEY</b>	
		d. STREET ADDRESS <b>RT. #1</b>	
3. <b>NAME OF DECEASED</b> (Type or print) First <b>MAXINE</b> Middle <b>L.</b> Last <b>LECHLITER</b>		4. <b>DATE OF DEATH</b> Month <b>MAY</b> Day <b>5</b> Year <b>19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-5-1919</b>
9. AGE (In years lay birthday) yrs. <b>47</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Blouse Factory</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>KEYSER, W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ROBERT SIMPSON</b>		14. MOTHER'S MAIDEN NAME <b>MARY ANDERSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. <b>INFORMANT</b>		Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>	
18. <b>CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Natural Hemorrhage</b> DUE TO <b>Cerebral ataxia Cerebral</b> stating the underlying cause last. (b) <b>Cerebral Cerebral</b> (c) <b>Cerebral Cerebral</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1918</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>2:26 PM</b> from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>L. LOUIS MOULD M.D.</b>		22d. ADDRESS <b>1068 NATIONAL HIGHWAY, LA VALE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 8, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Near Keyser, W.Va.</b>
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 17 1967</b>	
		25b. REGISTRAR'S SIGNATURE 	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF OHIO

00008

WEST VIRGINIA

ALLEGANY

RIDGELEY

9 DAYS

CHAMBERLAND

RT. 41

MEMORIAL HOSPITAL

U. S. DEPARTMENT

OF HEALTH

7-6-1919

FEWELL WHITE

USA

REYER, W. A.

HARRY ANDERSON

ROBERT SIMPSON

MEMORIAL HOSPITAL, CHAMBERLAND, W. V.

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1919

MAY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06038

CERTIFICATE OF DEATH

06027

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY in lb <b>1 DAY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>L.</b> Last <b>LEE</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>5</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 13, 1893</b> AGE (In years, Months, Days, Hours, Min.) <b>73 YRS.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>WILLIAM LEE</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA SHAHAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocarditis &amp; Decompensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 10, 1965</u> to <u>May 5, 1967</u> that (I) (we) last saw the deceased alive on <u>May 5, 1967</u> , and that death occurred at <u>6:55 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Co-Chief of Police</u> <u>Charles Judge</u>		22b. DATE SIGNED <u>5/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <b>DR. RICHARD J. WILLIAMS</b>		22d. ADDRESS <b>CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 8, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wotring Chapel</b>		23d. LOCATION (City or Town) (County) (State) <b>Rowlesburg, W. Va.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 17 1967</b>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

06082

ALLEGANY

CONTELAND

MEMORIAL HOSPITAL

ERNEST

MALE WHITE

WILLIAM LEE

1 DAY

LEE

WEST VIRGINIA

WEST VIRGINIA

REBECCA SHAW

MEMORIAL HOSPITAL, CONTELAND, MO.

DR. RICHARD J. WILLIAMS

CONTELAND, MO.

06082

ALLEGANY

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100 ROBERTS STREET

MAY

WEST VIRGINIA

U. S. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06039 CERTIFICATE OF DEATH 05028									
1. PLACE OF DEATH. a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					c. LENGTH OF STAY IN 1b <b>51 DAYS</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>					d. STREET ADDRESS <b>216 SARATOGA ST.</b>				
3. NAME OF DECEASED (Type or print) <b>MARY</b> First <b>R.</b> Middle <b>LINNANE</b> Last					4. DATE OF DEATH Month <b>MAY</b> Day <b>19</b> Year <b>1967</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/6/96</b>		9. AGE (In years last birthday) <b>70</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>ALLEGANY, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>JAMES MORGAN</b>					14. MOTHER'S MAIDEN NAME <b>ELLEN TEMPLETON</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL RECORD</b> Address <b>SACRED HEART HOSPITAL</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1913 Carcinoma of Cheek</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>DUE TO (b) Secondary Radiation Reaction - Cellulitis</b> <b>DUE TO (c) Fistula buccal due to (a)</b>									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>3/29</b> , 19 <b>67</b> , to <b>5/19</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>5/19</b> , 19 <b>67</b> , and that death occurred at <b>6:55</b> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <b>A. J. Hinkley</b>					22b. DATE SIGNED <b>5/21/67</b>		22c. PHYSICIAN'S NAME (Type) <b>A. J. Hinkley</b>		
22d. ADDRESS <b>A. J. Hinkley</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <b>5/23/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland MD</b>		
24. FUNERAL DIRECTOR <b>Louis Stein Inc. Cumb. MD</b>					25a. REC'D BY REGISTRAR <b>MAY 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06040

06029

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b> 01-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>81 Greene St.</b>				d. STREET ADDRESS <b>81 Greene St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Blanche</b> First Middle Last <b>---</b> <b>Lippold</b>				4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 9, 1898</b>		9. AGE (In years last birthday) yrs. <b>68</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Rwy.</b>		11. BIRTHPLACE (State or foreign country) <b>Barton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William H. Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth P. Turnbull</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No,</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Arlington, Va.</b> <b>Mr. George Thomas 4126 N. 26th Rd. 22207</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>May 7, 1967</b> Address (Street, city, town, or county) <b>Cumberland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/11/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>H. Wayne George Cumberland, Maryland</b>				25a. REC'D BY REGISTRAR <b>MAY 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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*James H. Smith*

JOHN H. SMITH, JR.

JOHN H. SMITH, JR.

JOHN H. SMITH, JR.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**06041**

**CERTIFICATE OF DEATH**

**06030**

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>31 DAYS</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>468 BALTIMORE AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>A.</b> Last <b>LITTEN</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>1</b> Year <b>1967</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-14-92</b>	
				9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND-CUMBERLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>MOONEY, ANDREW J.</b>				14. MOTHER'S MAIDEN NAME <b>DIGAN, JOHANNA M.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-16-4492</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the ovary with metastases to liver, colon, lymph nodes</b> 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State) <b>1967 5/2 67</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1967 3:00 P.M.</b> , 19 <b>5/2</b> , that (I) (we) last saw the deceased alive on <b>5/2</b> 19 <b>67</b> , and that death occurred at <b>5/2</b> 19 <b>67</b> , M, from causes and on the date stated above.							22b. DATE SIGNED <b>5/5/67</b>
22a. SIGNATURE <i>[Signature]</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>				22d. ADDRESS <b>CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 5, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md. Allegany</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 11 1967</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF OHIO

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CUMBERLAND

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MEMORIAL HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS HOSPITAL</b>		d. STREET ADDRESS <b>82 FROST AVENUE</b>	
3. NAME OF DECEASED (Type or print) <b>THOMAS PRICE LLEWELLYN</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>21</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 7, 1891</b>
9. AGE (In years lost birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERVISOR OF MAIN.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>REFRACTORIES</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PHILLIP LLEWELLYN</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET PRICE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>12-10-6300A</b>		17. INFORMANT <b>MRS. BEULAH LLEWELLYN, FROSTBURG, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED ANASARCA</b> DUE TO (b) <b>PRIMARY ANEMIA</b> DUE TO (c) <b>6 months</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/18/1967</b> , to <b>5/21/1967</b> , that (I) (we) lost saw the deceased alive on <b>5/21/1967</b> , and that death occurred on <b>5/21/1967</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>G. Paige Strong</b>		22b. DATE SIGNED <b>5/21/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. PAIGE STRONG</b>		22d. ADDRESS <b>167 E. MAIN ST. - FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MAY 24 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>F.B.G. MEMORIAL PARK</b>	23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MD.</b>
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR <b>MAY 25 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06043					06032				
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>48 MILL STREET</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> d. STREET ADDRESS <b>48 MILL STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>HENRY F. LLOYD</b>					4. DATE OF DEATH <b>MAY 10, 1967</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 12, 1901</b>		9. AGE (In years last birthday) <b>65</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED ENGINEER. DEPT. CELANESE CORPORATION</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
13. FATHER'S NAME <b>WM. H. LLOYD</b>					14. MOTHER'S MAIDEN NAME <b>MARGARET PATTERSON</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW1 214-07-6607A</b>		17. INFORMANT <b>HENRY LLOYD, FROSTBURG, MD.</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart failure</b> 4221 DUE TO (b) <b>Severe Bronchial asthmatic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>CVD</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day - years - years</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1962</b> to <b>May 10, 1965</b> , that (I) (we) last saw the deceased alive on <b>5/10 1962</b> , and that death occurred at <b>2 p.m.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>John B. Davis, M.D.</b>					22b. DATE SIGNED <b>5/12/67</b>				
22c. PHYSICIAN'S NAME (Type) <b>JOHN B. DAVIS, M. D.</b>					22d. ADDRESS <b>2 BROADWAY, FROSTBURG, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 13, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FBG. MEMORIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>			
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>					25a. REC'D BY REGISTRAR <b>MAY 15 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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*[Faint, mostly illegible text and markings covering the page, possibly bleed-through from the reverse side. Some faint words like "RECEIVED" and "NOV 19 1954" are visible.]*



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06044

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06033

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>Frostburg</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>			c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital</b>				d. STREET ADDRESS <b>308 E. Main</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Burman</b> Middle <b>T.</b> Last <b>Loar</b>				4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>19 67</b>				
5. SEX <b>M</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>12-30-80</b>		
9. AGE (In years last birthday) yrs. <b>86</b>		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Loar Town, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired blacksmith</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Coal mines</b>		13. FATHER'S NAME <b>Jacob Loar</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-03-4732A</b>		17. INFORMANT Address <b>Mrs. Novella Crowe, Frostburg, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Contusions of Brain</b> DUE TO <b>(Fall at Home)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fell at Home</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b> <b>3 Days</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at Home</b>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>9:00</b> <b>May 9</b> 19 <b>67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Frostburg, Alleg. Maryland</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 12, 1967</b> Address (Street, city, town, or county) <b>Cumberland, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 15 '67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Frostburg, Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Joseph R. Durst, Sr., Frostburg, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06045

CERTIFICATE OF DEATH

06034

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>22 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PATTERSON CREEK</b>		d. STREET ADDRESS <b>15-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PARKER</b> Middle <b>P.</b> Last <b>LOGSDON</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>1</b> Year <b>67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-12-1895</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired B &amp; O Signalman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LOGSDON, GEORGE</b>		14. MOTHER'S MAIDEN NAME <b>ALCARR, MARGARET</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-05-1818</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism, Obstructive</b> <b>163X</b> DUE TO <b>Acute Thrombo-phlebitis L.L. leg</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma Rt. Lung with generalized metastases 8 months</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>20 hrs</b> <b>48 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>1 May 1967</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1 July 66, 195:25 P.M.</b> , 19__, that (I) (we) last saw the deceased alive on <b>1 May 1967</b> , and that death occurred at <b>5:25 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>W. Alfred Van Ormer</b>		22b. DATE SIGNED <b>1 May 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>		22d. ADDRESS <b>CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/4/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Ashby Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Fort Ashby Mineral W. Va</b>	
24. FUNERAL DIRECTOR <b>H. Lee Silcox 404 Decatur St, Cumberland, Md</b>		25a. REC'D BY REGISTRAR <b>MAY 4 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02036

STEWART, D. J.

02036

WEST VIRGINIA

ALLEGANY

PATRICIA GREEN

22 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

67

WV

LOSDON

P.

PARKER

3-12-1964

WHITE

MALE

ALCANT, TARGATE

LEAPRO, GEORGE

MEMORIAL HOSPITAL, CUMBERLAND, MD.

JOHN FORD

CUMBERLAND, MD.

DR. W. J. VAN ORNER

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06046

CERTIFICATE OF DEATH

06035

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Westernport</b>		c. LENGTH OF STAY IN TB <b>63 Yrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Westernport</b>		d. STREET ADDRESS <b>811</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Samuel</b> Last <b>Machin</b>		4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1886</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>24</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Garrett Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John T. Machin</b>		14. MOTHER'S MAIDEN NAME <b>Emma Handley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-07-7244</b>	
17. INFORMANT <b>Emma Stemp-Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> DUE TO (b) <b>Chronic Bronchitis with Asthma</b> DUE TO (c) <b>20 Years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 10, 1965</b> , to <b>May 24, 1967</b> , that (I) (we) last saw the deceased alive on <b>May 23 1967</b> , and that death occurred at <b>7:45 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Paul R. Wilson</b>		22b. DATE SIGNED <b>May 24, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Paul R. Wilson</b>		22d. ADDRESS <b>Piedmont, W. Va.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 26, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>	23d. LOCATION (City or Town) (County) (State) <b>Westernport Md.</b>
24. FUNERAL DIRECTOR <b>E. J. Boral</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 29 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
Item #9 Film #G389 6/5/67														
06047					CERTIFICATE OF DEATH					06036				
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>1MO 7DA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>309 DECATUR STREET</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>HAZEL</b> Middle <b>B.</b> Last <b>MALLOY</b>					4. DATE OF DEATH Month <b>MAY</b> Day <b>26</b> Year <b>1967</b>									
SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-7-1903</b>		9. AGE (In years lost birthday) <b>63 64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PIEDMONT, W. VA.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>DAVID BRADENBERG</b>					14. MOTHER'S MAIDEN NAME <b>BESSIE RAWLINGS</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS-PRIMARY IN UTERUS</b> <b>174X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 YRS</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>3-5</b> , 19 <b>64</b> , to <b>5-26</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>5-26</b> , 19 <b>67</b> , and that death occurred at <b>9:00 PM</b> from causes and on the date stated above.														
22a. SIGNATURE <b>Thomas F. Lusby</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/27/67</b>							
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. LUSBY, M.D.</b>					22d. ADDRESS <b>932 NATIONAL HIGHWAY, CUMBERLAND, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>MAY 29, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PHILOS CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>WESTERNPORT, MD.</b>						
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>					ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR <b>JUN 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

00038

00037

ALLIANCE

MARYLAND

CUNNINGHAM

AND JDA

300 DECATUR STREET

HOSPITAL

25 MAY 1954

2-2-1003

PIDMONT, W. VA.

BESSIE BAWLING

DAVID BRADSHAW

HOSPITAL, CHURCHLAND, MD.

CARLTON, MD. 11111

THOMAS F. LUSBY, M.D., 11111

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06048

06037

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>4 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RT. 1, MT. SAVAGE, MD. 01-1</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>L</b> Last <b>MALLOY</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>11</b> Year <b>19 67</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-2-02</b>	
9. AGE (In years lost birthday) yrs. <b>64</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b> Hours <b>1</b> Min. <b>0</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MT. SAVAGE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REPAIR MAINT. MECHANIC</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CELANESE</b>		13. FATHER'S NAME <b>LAWRENCE MALLOY</b>	
13. FATHER'S NAME <b>LAWRENCE MALLOY</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE WILLS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-05-4614</b>		17. INFORMANT <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-massive Coronary Thrombosis</b> <b>1201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Dissecting Aortic Aneurysm</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dissecting Aortic Aneurysm</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> to <b>May 11, 1967</b> , that (I) (we) last saw the deceased alive on <b>5/11/67</b> , and that death occurred at <b>1:10 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>DR. OVERTON HIMMELWRIGHT</b>				22b. DATE SIGNED <b>5/15/67</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. OVERTON HIMMELWRIGHT</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-15-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. PATRICK'S CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>MT. SAVAGE, MD.</b>	
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>				25a. REC'D BY REGISTRAR <b>MAY 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

05082

ALLIANCE

COMMERCIAL

MEMORIAL HOSPITAL

JOSEPH

NAME

WIFE

-2-02

BA

CHURCH

ST. ANNE'S

LAWRENCE MALLORY

WHITE WILDS

MT. SAVAGE, MD.

U.S.A.

STATION

MEMORIAL HOSPITAL

ETHIOPIA, MT.

DR. OVERTON WIMBUSH

CHURCH, MD.

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FOR STATE  
HEALTH DEPT

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06043

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06038

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Mineral</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>?</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Ashby</b> <b>85-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D. O. A. Sacred Heart Hospital</b>				d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Vernon</b> Last <b>Marker</b>				4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 26, 1902</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10. UNDER 1 YEAR Months <b>6</b> Days <b>19</b>		11. UNDER 24 HRS Hours <b>6</b> Min <b>19</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired Blacksmith</b>		11. BIRTHPLACE (State or foreign country) <b>Fort Ashby, W. Va.</b>	
13. FATHER'S NAME <b>Jacob Marker</b>				14. MOTHER'S MAIDEN NAME <b>Atha Berry</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.  		17. INFORMANT <b>Mr. Robert O. Billmyre, Fort Ashby, W. Va.</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> (c) <b>---</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lymphosarcoma</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  		20f. (City or town) (County) (State)  	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D. EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic, M. D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>May 7, 1967</b> 22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Rt. 9 Cumberland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 8, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Ashby Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Fort Ashby, W. Va. Mineral</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Allegany</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Oldtown Rural</b>			c. LENGTH OF STAY in 1b <b>20 yrs.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Oldtown Maryland</b>			d. STREET ADDRESS <b>Oldtown Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Oldtown Md.</b>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Dory William Mc Bride</b>					4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1967</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 14, 1905</b>		9. AGE (In years last birthday) <b>61</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>			11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Luthen Mc Bride</b>					14. MOTHER'S MAIDEN NAME <b>Elsie Kidwell</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>—</b>				
17. INFORMANT <b>Cleo Mc Bride</b>					Address <b>Oldtown Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 16, 1967</b> DATE SIGNED ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D. EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b> Address (Street, city, town, or county) <b>Cumberland, Maryland</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>May 19, 67</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Pine Hill Cemetery</b> 22d. LOCATION (City, town, or country) (State) <b>Oldtown Md</b> 23. FUNERAL DIRECTOR <b>Louis Stein Inc. Cumb. Md</b> 24a. REC'D BY REGISTRAR <b>MAY 22 1967</b> 24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

XX May 16, 1967  
Cumberland, Maryland

May 17, 67 Pine Hill Cemetery

Benedict Skirvelle, M.D.

Citizens Rd

X

X

X

CORONARY SCLEROSIS

CORONARY OCCLUSION

Citizens Rd.

Lucas No Bride

Elaine Kishell

Farmer

Farmer

West Virginia

U.S.A.

White

July 14, 1904

Boy

William

White

May

May 16, 1967

Citizens Rd.

Citizens Rd.

40 yrs.

Citizens Maryland

Citizens Maryland

Allegany

Maryland

Allegany

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
06051 CERTIFICATE OF DEATH 06040										
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McCoole</u>			c. LENGTH OF STAY IN 1b <u>3 Wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>McMullen Highway</u>					d. STREET ADDRESS <u>749 Maryland Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Mary</u> <u>Katherine</u> <u>McFarland</u>			First Middle Last		4. DATE OF DEATH <u>May</u> <u>19</u> <u>67</u>		Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>June 3, 1907</u>		9. AGE (In years last birthday) <u>59</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
13. FATHER'S NAME <u>Mark E. Free</u>					14. MOTHER'S MAIDEN NAME <u>Emily Virginia Kuhn</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Virginia Northcraft Keyser, W. Va.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma from</u> <u>170X</u> DUE TO (b) <u>Left Breast (Carcinoma, scutcheon)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>1964</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 16</u> , 19 <u>64</u> , to <u>May 19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-25</u> 19 <u>67</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>Carlton Brinsfield</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-20-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>CARLTON BRINSFIELD MD</u>					22d. ADDRESS <u>401 DECATUR ST.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 23, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prosperity Methodist Cem</u>		23d. LOCATION (City, town or county) (State) <u>Near Cumberland, Maryland</u>				
24. FUNERAL DIRECTOR <u>John J. Hafer, Jr.</u>					ADDRESS <u>230 Balto Ave.,</u>		25a. REC'D BY REGISTRAR <u>MAY 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
					Cumberland,				Md	

1992

5206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MD  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06052

CERTIFICATE OF DEATH

06041

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>16 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>Gordon</b> Last <b>MC GINN</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>1</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-2-1928</b>
9. AGE (In years lost birthday) yrs. <b>38</b>		10. IF UNDER 1 YEAR Months Days Hours Mm. <b>38</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Assoc. Amer. Trucking</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>FROSTBURG, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM MC GINN</b>		14. MOTHER'S MAIDEN NAME <b>ANNA HOLSINGER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-24-6693</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> DUE TO <b>Cirrhosis of Liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Duodenal ulcer</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home; farm; factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>15 Apr 1967</b> to <b>1 May 1967</b> , that (I) (we) last saw the deceased alive on <b>1 May 1967</b> , and that death occurred at <b>10:40 PM</b> on causes and on the date stated above.			
22a. SIGNATURE <b>Andrew Stasko</b>		22b. DATE SIGNED <b>5/3/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ANDREW STASKO, M.D.</b>		22d. ADDRESS <b>401 DECATUR ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/4/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Eckhart, Allegany, Maryland</b>
24. FUNERAL DIRECTOR <b>H. Wayne George Cumberland, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 5 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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ALLEGANY

WABYLAND

CUMBERLAND

10 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

300 COLUMBIA ST.

THOMAS

GRAND

NO. 12-2-1038

WHITE

WILL

LABORER

WILLIAM MC CORM

PROTESTANT, W.

ANNA HOSINGER

212-11-682

MEMORIAL HOSPITAL

CUMBERLAND, MD.

ANDREW STARK, M.D.

301 DECATUR ST., CUMBERLAND, MD.

212-11-682

LABORER, WABYLAND, MD.

1. 212-11-682 CUMBERLAND, MD.

1. 212-11-682



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06053

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06042

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. LENGTH OF STAY IN 1b <b>10 Minutes</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		d. STREET ADDRESS <b>Division Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Leo</b> Last <b>McKenzie</b>		4. DATE OF DEATH Month <b>May</b> Day <b>14</b> , Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 5, 1948</b>
9. AGE (In years last birthday) yrs. <b>19</b>		IF UNDER 1 YEAR Months <b>19</b> Days <b>14</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting Contr.</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>P. William McKenzie</b>		14. MOTHER'S MAIDEN NAME <b>Margaret T. Flynn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No,</b>		16. SOCIAL SECURITY NO. <b>218-48-9995</b>	
17. INFORMANT <b>Mr. P. William McKenzie</b>		Address <b>Cumb. Md. Box 51E Fairgo,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemothorax, Left</b> <b>825.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ruptured Left Lung</b> DUE TO (c) <b>Compression of Chest</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Sudden</b> <b>----</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver in a one car accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>9:00 a.m. May 14, 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work at work <b>W. Va. Rt. # 28</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Nr. Fort Ashby Hampshire,</b>		20f. (City or town) (County) (State) <b>W. Va.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>May 14, 1967</b>	
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/17/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany Md.</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George</b>		25a. REC'D BY REGISTRAR <b>MAY 18 1967</b>	
ADDRESS <b>Cumberland, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06054

06043

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>27 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>M.</b> Last <b>MC VICKER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>14</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-17-90</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>6</b> Hours <b>16</b> Min.	11. IF UNDER 24 HRS. Hours <b>16</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>DAWSON, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EVAN SIGLER</b>		14. MOTHER'S MAIDEN NAME <b>MARY A. FORTHMAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arterio Sclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>4-16-67</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4-16-1967</b> to <b>5-14-1967</b> , that (I) <del>was</del> last saw the deceased alive on <b>5-13-1967</b> , and that death occurred at <b>6:25A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Wm. F. Williams</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>5-15-67</b>
22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>		22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/16/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>	23d. LOCATION (City or Town) (County) (State) <b>Westernport Md.</b>
24. FUNERAL DIRECTOR <b>E. L. Bova</b>		ADDRESS <b>Westernport, Md.</b>	25a. REC'D BY REGISTRAR <b>MAY 18 1967</b>
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY MEDICAL DEPARTMENT  
ON 10-10-1918

08043

08043

ALLEGANY

WYLAND

ALLEGANY

BOX 244, BARTON, W.

27 DAYS

CHANDLER

US ARMY HOSPITAL

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WIC VICTOR

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VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
06055 Items #16, 26, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland Mt. Savage</b>		c. LENGTH OF STAY IN 1b <b>17 32 YEARS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>P.O. BOX 537, CUMB., MD.</b>	
3. NAME OF DECEASED (Type or print) <b>WALTER Middle FRANCIS Last MEADE</b>		4. DATE OF DEATH Month <b>5</b> Day <b>5</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-18-06</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kelly Springfield Tire Co</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SR. CLERK</b>	9. AGE (in years last birthday) <b>61</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>RICHARD MEADE</b>		14. MOTHER'S MAIDEN NAME <b>MATHILDA (REITH)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-07-0834</b>	
17. INFORMANT <b>Hospital Admis-Address</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage secondary to</b> <b>454X</b> DUE TO (b) <b>insertion of Y graft from terminal</b> DUE TO (c) <b>aorta to femoral arteries because of Leish's</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Syndrome</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <b>DR. E. R. PAUL</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>36 GREENE ST., CUMB., MD. 21502</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>5/8/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cem.</b>	23d. LOCATION (City, town or county) (State) <b>Mt Savage Md.</b>
24. FUNERAL DIRECTOR <b>Louis Stein Inc. Cumb. Md</b>		25a. REC'D BY REGISTRAR <b>MAY 8 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

0022

32 YEARS

ST. JOHN'S HOSPITAL

MALE

WHITE

WHITE

MALE

WHITE

2-18-05

NEW YORK, N. Y.

HATFIELD (BETH)

RICHMOND, N. Y.

RECORDS

012-007-0001

30 GREENE ST., CORN., N.Y. 21202

DR. J. R. PAUL



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06056

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06045

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>70 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland, Md.</b>		01/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>429 Homer Street</b>		d. STREET ADDRESS <b>429 Homer Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elsie</b> Middle <b>Marie</b> Last <b>Morris</b>		4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1895</b>
9. AGE (In years last birthday) <b>71</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Dobbins, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John E. Squires</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Kieffner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mr. Chester A. Squires, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>CORONARY SCLEROSIS</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> -----			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		22. DATE SIGNED <b>May 19, 1967</b> <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 22, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md. Allegany</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 23 1967</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1950

1950

*Remnant of the*

FOR STATE  
HEALTH DEPT.

06057

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06046

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>71 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>18 Boone Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>E.</b> Last <b>Nee</b>				4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Oct. 31, 1895</b>		9. AGE (In years last birthday) yrs. <b>71</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Municipal</b>		11. BIRTHPLACE (State or foreign country) <b>Keyser, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James A. Nee</b>				14. MOTHER'S MAIDEN NAME <b>Delia Lee</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes War I</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Florence Nee, Cumberland, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>24 Hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D. EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 25, 1967</b> Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 29, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md. Allegany</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 31 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SECRET

FOR STATE  
HEALTH DEPT.

06058

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06047

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>66 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1 South Terrace</b>		d. STREET ADDRESS <b>1 South Terrace</b>	
3. NAME OF DECEASED (Type or print) <b>Joseph Peter Nies</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1900</b>
9. AGE (In years last birthday) yrs. <b>66</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tire Industry</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew Nies</b>		14. MOTHER'S MAIDEN NAME <b>Clara B. Sell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Leota Nies, Cumberland, Md.-Wife</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> (c) <b>---</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D. EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> May 16, 1967. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rt. 9 Cumberland Md. Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 20, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md. Allegany</b>
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 19 1967</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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*Amantia*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06059					CERTIFICATE OF DEATH			06048	
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>2/23/1967</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Allegany County Infirmary</b>					d. STREET ADDRESS <b>26 Grant Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Janet Penn Park</b>			First Middle Last		4. DATE OF DEATH <b>May 20, 1967</b>		Month Day Year		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/2/1876</b>		9. AGE (In years last birthday) <b>90</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Lonaconing, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Taylor</b>					14. MOTHER'S MAIDEN NAME <b>Jane Robertson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>P. O. Box 599, Address: Cumberland, Md. Allegany County Infirmary records.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Failure</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>yes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Parkinson's Disease</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>2/23/67</b> , 19__, to <b>5/20/67</b> , 19__, that (I) (we) last saw the deceased alive on <b>5/20/67</b> , 19__, and that death occurred at <b>P. M.</b> , from causes and on the date stated above. at <b>9:55 P. M.</b>									
22a. SIGNATURE <b>George M. Simons</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5/22/1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>George M. Simons, M. D.</b>					22d. ADDRESS <b>Memorial Hospital, Cumberland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-24-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Frostburg, Md.</b>		
24. FUNERAL DIRECTOR <b>Joseph R. Durst, Sr.,</b> <b>Frostburg, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>MAY 25 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

00032

CERTIFICATE OF DEATH

00032

First Name

Second Name

Third Name

Sex

Age

1

2

3

4

1/1/1

2/2/1

3/3/1

4/4/1

5/5/1

6/6/1

7/7/1

8/8/1

9/9/1

10/10/1

11/11/1

12/12/1

13/13/1

14/14/1

15/15/1

3 1

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06060

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06049

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Mineral</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>853</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>99 Memorial Hosp. (D.O.A.)</u>		d. STREET ADDRESS <u>21 Mineral St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Mae</u> Last <u>Parrish</u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1/1881</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Limestone, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Davis</u>		14. MOTHER'S MAIDEN NAME <u>Armanda Dixon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Lloyd Ellifritz</u>		Address <u>Ridgeley, W. Va.</u> <u>21 Mineral St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>CORONARY SCLEROSIS</u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>---</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Noturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>		22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 13, 1967</u> Address (Street, city, town, or county) <u>Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/15/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Queens Point Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Keyser, Mineral, W. Va.</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 18 1967</u>	
ADDRESS <u>Cumberland, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06061

CERTIFICATE OF DEATH

06050

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FROSTBURG</u>			c. LENGTH OF STAY IN 1b <u>5 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRANTSVILLE</u> <u>11.2</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MINERS HOSPITAL</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>A.</u> Last <u>PETENBRINK</u>				4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 22 1993</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u>		11. IF UNDER 24 HRS. Hours <u></u> Min <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>SCOTTSDALE, PA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JACOB GEIGER</u>				14. MOTHER'S MAIDEN NAME <u>MELINDA BITTNER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>194-03-1466</u>		17. INFORMANT <u>PAUL PETENBRINK</u>		Address <u>16 GROVE ST. SCOTTSDALE, PA.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC BRAIN SYNDROME</u> DUE TO (b) <u>CIRCULATORY DISTURBANCE</u> DUE TO (c) <u>CEREBRAL ARTERIOSCLEROSIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 YEARS</u> <u>5 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTESTINAL OBSTRUCTION DUE TO FECAL IMPACTION</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 13, 1964</u> to <u>MAY 4 1967</u> that (I) (we) last saw the deceased alive on <u>MAY 4 1967</u> , and that death occurred at <u>4:10 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>A. Paige Strong</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A. PAIGE STRONG</u>				22d. ADDRESS <u>Frostburg, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-8-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WHITE OAK</u>		23d. LOCATION (City or Town) (County) (State) <u>WELLSBURG, SUMMERS, PA.</u>	
24. FUNERAL DIRECTOR <u>Monksant</u> <u>Bentley H. Monksant</u> <u>Inter-Southern Funeral Home</u>				25a. REC'D BY REGISTRAR <u>MAY 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

0520

10320

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06062

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06051

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Flintstone Rt #2</b>		c. LENGTH OF STAY IN 1b <b>24 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pleasant Valley Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edgar</b> Middle <b>Cecil</b> Last <b>Rephann</b>		4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1901</b>
9. AGE (In years lost birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Eckhart Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph E. Rephann</b>		14. MOTHER'S MAIDEN NAME <b>Martha Willison</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>177-01-0733</b>	
17. INFORMANT <b>Mrs. Blanche Rephann</b>		Address <b>Route #2 Flintstone, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO (b) <b>CORONARY THROMBOSIS</b> DUE TO (c) <b>CORONARY SCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED <b>May 27, 1967</b>		23. ADDRESS (Street, city, town, or county) <b>Cumberland, Md.</b>	
24. ACTUAL SIGNATURE <b>Benedict Skitarelic, M.D.</b>		25. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
26a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	26b. DATE THEREOF <b>5/27/67</b>	26c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>	26d. LOCATION (City or Town) (County) (State) <b>Eckhart Allegany Maryland</b>
27. FUNERAL DIRECTOR <b>H. Lee Silcox Cumberland Maryland 21502</b>		28. REC'D BY REGISTRAR DATE <b>MAY 29 1967</b>	
29. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		30. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06063

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06052

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Flintstone Route #2</u>			c. LENGTH OF STAY IN 1b <u>20 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Flintstone Route #2</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Ernest</u> Last <u>Rephann</u>				4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1875</u>		9. AGE (In years lost birthday) <u>92 yrs.</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Consol Coal Co</u>		11. BIRTHPLACE (State or foreign country) <u>Eckhart, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Rephann</u>				14. MOTHER'S MAIDEN NAME <u>Mary Leidinger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-6488</u>		17. INFORMANT Address <u>Route #2</u> <u>Flintstone, Maryland</u> <u>Edgar C. Rephann</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 3, 1967</u> Address (Street, city, town, or county) <u>Cumberland, Md.</u>		22. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Eckhart Allegany Maryland</u>	
24. FUNERAL DIRECTOR <u>H. Lee Silcox 404 Decatur St Cumberland, Md</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>06064</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>06053</span> </div> <div style="text-align: center;"> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>48 HOURS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL, CUMB., MD. 21502</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD. 21502 01-1</b> d. STREET ADDRESS <b>39 WEMPE DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <b>JOHN</b> Middle <b>W.</b> Last <b>RHOE</b>			<b>4. DATE OF DEATH</b> Month <b>MAY</b> Day <b>12</b> Year <b>1967</b>						
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>MARCH 11, 1904</b>		<b>9. AGE</b> (In years last birthday) <b>63</b> yrs. IF UNDER 1 YEAR: Months <b>2</b> Days <b>1</b> IF UNDER 24 HRS.: Hours <b></b> Min. <b></b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>PIPE FITTER</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>CELANESE CORP.</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>SLEEPY CREEK, WEST VA.</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>JOHN W. RHOE</b>					<b>14. MOTHER'S MARIEN NAME</b> <b>MILLER, MARY ELLEN</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>			<b>16. SOCIAL SECURITY NO.</b> <b>214-07-4106</b>		<b>17. INFORMANT</b> Address <b>HOSPITAL ADMISSION FORM</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Pneumonia</i> <b>154x</b> DUE TO <i>Heart and Lung Failure Unknown</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>He operated on for Curvature of</i> DUE TO <i>Pneumonia 3 years ago</i> (c)									<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 days</b> <b>3 days</b>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>									<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>May 10</i> , 19 <b>67</b> , to <i>May 12</i> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <i>May 12</i> , 19 <b>67</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <i>B. M. Schindler</i>					<b>22b. DATE SIGNED</b> <b>5/11/67</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>DR. B. SCHINDLER</b>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>					<b>23b. DATE THEREOF</b> <b>May 15, 1967</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Mary's Cemetery</b>		<b>23d. LOCATION (City, town or county)</b> (State) <b>Cumberland, Md. Allegany</b>
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>					<b>25a. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles J. [Signature]</i>		

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CONTRACT NO. 21502

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CONTRACT NO. 21502

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HILLER, (MR. ELLER)

JOHN W. BHOE

HOSPITAL ADMISSION FORM

21-07-410

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3 GREENE ST. CONVENT, N. 21

DR. J. S. HOLER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1-67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06065

CERTIFICATE OF DEATH

06055

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>17 NORTH ALLEGANY ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>L.</b> Last <b>SCHACK</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>28</b> Year <b>19 67</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-9-1900</b>		9. AGE (In years lost birthday) yrs. <b>66</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Head Draftsman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fire Co Kelly Springfield</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>CHARLES F. SCHACK</b>				14. MOTHER'S MAIDEN NAME <b>IDA DAVID</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW 1</b>		16. SOCIAL SECURITY NO. <b>492-03-8330</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>adenocarcinoma colon with metastasis</b> <b>1538</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>to liver and terminal cachexia</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3+ years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio-sclerotic vascular disease with cerebral vascular accident</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>August 1966</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>May 28 1967</b> , and that death occurred at <b>8:30 p.m.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>W. G. H. Faw Jr.</b>				22b. DATE SIGNED <b>May 29 67</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. WYLIE M. FAW JR.</b>				22d. ADDRESS <b>CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6/1/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>	23d. LOCATION (City or Town)	(County)	(State) <b>Alleg Md.</b>		
24. FUNERAL DIRECTOR <b>John J. Hafer, Jr., 230 Balto Ave, Cumberland Md</b>			25a. REC'D BY REGISTRAR <b>JUN 5 1967</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Hafer Jr.</b>			

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ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

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CHARLES F. SCHACH

ITA DAVID

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CUMBERLAND

17 NORTH ALLEGANY ST.

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ALLEGANY

ALLEGANY

CUMBERLAND, W.V.

DR. WYLLIE T. TAYLOR



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06066

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06056

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>Rt. # 1 Mt. Savage</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hosp. (D.O.A.)</u>		d. STREET ADDRESS <u>Community of Barreelsville</u>	
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>McKinley</u> Last <u>Shoemaker</u>		4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/10/1896</u>
9. AGE (In years last birthday) yrs. <u>70</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Utility Workman (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Company</u>	
11. BIRTHPLACE (State or foreign country) <u>Meyersdale, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Shoemaker</u>		14. MOTHER'S MAIDEN NAME <u>Jane Bare</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-05-7688</u>	
17. INFORMANT <u>Mrs. Mary S. Shoemaker</u>		Address <u>Rt. 1 Mt. Savage, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CORONARY SCLEROSIS</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN DEATH AND DEATH <u>SUDDEN</u> -----	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 12, 1967</u> Address (Street, city, town, or county) <u>Cumberland, Md.</u>	
22. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/15/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Restlawn Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>LaVale, Allegany, Md.</u>
24. FUNERAL DIRECTOR <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Md.</u>	
25a. REC'D BY REGISTRAR <u>MAY 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06067

06057

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, - write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>16:30 Hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles ----- Sisler</b>		4. DATE OF DEATH <b>May 27 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-27-1880</b>
9. AGE (In years lost birthday) <b>87</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Sisler</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Reynolds</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>159-12-4626</b>	
17. INFORMANT <b>Memorial Hospital-Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aspiration of Stomach Contents</b> DUE TO (c) <b>Multiple injuries</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Fractures of both legs; Fracture of Ribs</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by auto</b>	
20c. TIME OF INJURY Month, Day, Year <b>9:10 p.m. May 26 1967</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 35</b>		20f. (City or town) <b>Ellerslie, Allegany, Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>May 27, 1967</b>	
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D. EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 30, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hyndman Cemetery</b>	
23d. LOCATION (City or Town) <b>Hyndman, Bedford Co., Pa.</b> (County) (State)		25a. REC'D BY REGISTRAR <b>JUN 2 1967</b> 25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	
24. FUNERAL DIRECTOR <b>Harvey N. Zeigler</b>		ADDRESS <b>Hyndman, Pa.</b>	

05054

05054

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06068

CERTIFICATE OF DEATH

07520

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. VIRGINIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b>		c. LENGTH OF STAY IN lb <b>1 DAY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ARLIE</b> Middle <b>R.</b> Last <b>STARKEY</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>31</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-7-19</b>
9. AGE (In years lost birthday) <b>47</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales lady</b>	11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA Perkins</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>UEL RICHARDS</b>	
14. MOTHER'S MAIDEN NAME <b>BELLE IOWA SEAL</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic - Secondary - Carcinoma</b> DUE TO (b) <b>Metastatic Thyroid Carcinoma</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 9 1966</b> to <b>May 1967</b> , that (I) (we) last saw the deceased alive on <b>5/31/67</b> 19, and that death occurred at <b>50A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>DR. OVERTON HIMMELWRIGHT</b>		22b. DATE SIGNED <b>6/2/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. OVERTON HIMMELWRIGHT</b>		22d. ADDRESS <b>CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 5, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Clarksburg, W. Va.</b>
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 9 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6668

REPORT OF DEATH

ALLIANCE

W. VIRGINIA

CHURCHLAND, MD.

1 DAY

PT. ASHBY, W. VA.

ARLIE

STARKEY

MAY

REMAINS WHITE

7-7-1

TX

DELLS FOW

DEL RICHARDS

MEMORIAL - ORIGIN

CHURCHLAND, MD.

CHURCHLAND, MD.

CP. OVERSEA, W. VIRGINIA

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06069

06058

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>50 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Memorial Hospital D. O. A.</b>				d. STREET ADDRESS <b>717 Cepart Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Malcolm</b> Last <b>Taylor</b>				4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1889</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months <b>17</b> Days <b>19</b> Hours <b>67</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boiler Maker</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>City Rec. Dept</b>			11. BIRTHPLACE (State or foreign country) <b>Patterson Creek W Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Edward J. Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Alice Rienhart</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Edward R. Taylor</b>				Address <b>Cumberland Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY SCLEROSIS</b> (a), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 17, 1967</b>			
Address (Street, city, town, or county) <b>Cumberland, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 20, 67</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Allegany Md.</b>			
23. FUNERAL DIRECTOR <b>Stein's Fun. Home, 117 Fredk. St.,</b> <b>Cumberland, Md.</b>				24a. PLACE OF REGISTRATION <b>MAY 22 1967</b>			
				24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



0008

Allegany

West Virginia

20 yrs

Charleston

WV State Univ

Memorial Hospital

Edward

Marion

Taylor

May

19 07

Male

White

X

X

May 16, 1889 78

Boiler Maker

City Rec Dept

Western Creek W. Va. U. S. A.

Edward J. Taylor

Alice Blanche

Edward H. Taylor

CORONARY COMMISSION

CORONARY COMMISSION

X

X

X

May 17, 1907  
Charleston, West Virginia

BLANCHETT SMITH, W.D.

May 20, 07 Hillcrest Hotel Park, Charleston, West Virginia

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06070

06059

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN lb <b>35 Years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>725 N. Mechanic Street</b>				d. STREET ADDRESS <b>725 N. Mechanic Street</b>			
3. NAME OF DECEASED (Type or print) <b>Ressie LaFayette Teter</b>				4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1914</b>		9. AGE (In years lost birthday) <b>52 yrs.</b>		10. IF UNDER 1 YEAR Months <b>01</b> Days <b>1</b> Hours <b>00</b> Min <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail Grocer Employee</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Wymer, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Barn Teter</b>				14. MOTHER'S MAIDEN NAME <b>Esta Lambert</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-5598</b>		17. INFORMANT <b>Mrs. Cynthia Teter</b>		Address <b>124 East Avenue Hagerstown, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) <b>STUDDEN</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my apinain death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarellic</b> M.D.				22. DATE SIGNED <b>MAY 6, 1967</b>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				Address (Street, city, town, or county) <b>Cumberland, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/9/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Maryland</b>	
24. FUNERAL DIRECTOR <b>H. Lee Silcox 404 Decatur St Cumberland, Md</b>				25a. REC'D BY REGISTRAR <b>MAY 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1002

1002

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
 Item #2 infor, taken from birth cert.

06071

**CERTIFICATE OF DEATH**

06060

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Alleg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>			c. LENGTH OF STAY in 1b <b>1 DAY</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>			01.1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS HOSPITAL</b>				d. STREET ADDRESS <b>Rt. 2 Box 306</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BABY BOY</b> Middle <b>THUSS</b> Last <b>THUSS</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>23</b> Year <b>19 67</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 22, 1967</b>		9. AGE (In years last birthday) yrs. <b>1</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>	IF UNDER 24 HRS Hours <b>1</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>FROSTBURG, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <b>CAROL THUSS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>_____</b>		17. INFORMANT <b>CHARLES THUSS, RT. 2, BOX 306, FROSTBURG, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature Birth 1#93</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>26 hrs</b> DUE TO (c) <b>Interval between onset and death</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 22, 1967</b> to <b>May 23, 1967</b> , that (I) (we) lost the deceased alive on <b>May 23, 1967</b> , and that death occurred at <b>2 P. M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>John B. Davis</b>		M.D. <b>JOHN B. DAVIS, M. D.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>5/26/67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
<b>JOHN B. DAVIS, M. D.</b>		<b>2 BROADWAY, FROSTBURG, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MAY 24 '67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BIERTOWN CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>RAWLINGS, MD.</b>			
24. FUNERAL DIRECTOR <b>J. R. DURST, S.R., FROSTBURG, MD.</b>		ADDRESS	25a. REC'D BY REGISTRAR DATE <b>MAY 29 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

VR A15 (4)  
25M 1/67

7-273521

1 DAY

MAY 22, 1967

FROSTBURG, MARYLAND

CAROL THURS

U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

BP

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06072

06061

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>1 DAY 16 HR</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>511 CITY VIEW TERRACE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DARWIN</b> Middle <b>D.</b> Last <b>TREXLER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>20</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1901</b> <b>9-14-1901</b>
9. AGE (In years lost birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Locomotive Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GRANT TREXLER</b>		14. MOTHER'S MAIDEN NAME <b>ALICE WINDELL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-10-8470</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocarditis &amp; Decompensation</b> DUE TO (c) <b>Coronary sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 min.</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MAY 18</b> , 19 <b>67</b> , to <b>MAY 20</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>MAY 20</b> , 19 <b>67</b> , and that death occurred at <b>5:30 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Clay E. Durrett</b> M.D.		22b. DATE SIGNED <b>5/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CLAY E. DURRETT, MD.</b>		22d. ADDRESS <b>236 VIRGINIA AVE., CUMBERLAND, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 23, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Cumberland Alleg Md.</b>	
24. FUNERAL DIRECTOR <b>John J. Nafer, Jr.</b> Address <b>230 Balto Ave. Cumberland Md</b>		25a. REG'D BY REGISTRAR <b>MAY 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

19004

ALLEGANY

MARYLAND

CUMBERLAND

1 DAY 18 HR

311 CITY VIEW TERRACE

MEMORIAL HOSPITAL

MAY 20

TREXLER

D.

BARBIE

62

9-14-62

WHITE

MALE

RETIRED

W. VA.

ALICE WINNELL

GRANT TREXLER

MEMORIAL HOSPITAL, CUMBERLAND, MD.

62

MAY 20

MAY 11

62

MAY 20

CLAY E. DUBRETT, MD.

230 VINCENNE AVE., CUMBERLAND, MD.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06073

06062

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>73</b> Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				d. STREET ADDRESS <b>521 Lowell Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Clarence Denzil Valentine, Sr.</b>				4. DATE OF DEATH Month Day Year <b>May 10 19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 20- 1893</b>	
9. AGE (In years lost birthday) <b>73</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life) <b>Retired clerk Trial Magistrate Court</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George P. Valentine</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane McVicker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-28-9438</b>		17. INFORMANT Address <b>1914 Bedford St Cumberland, Md</b> <b>Clarence D. Valentine, Jr</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> DUE TO (b) <b>Pulmonary Fibrosis; Emphysema; Marked</b> DUE TO (c) <b>---</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Noturol causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>							
22. DATE SIGNED <b>May 10, 1967</b>				23. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			
24. FUNERAL DIRECTOR <b>H. Lee Silcox</b>				25. REC'D BY REGISTRAR <b>MAY 11 1967</b>			
26. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				27. DATE THEREOF <b>5/13/67</b>			
28. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>				29. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Maryland</b>			

83070

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06074					06063				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>ALLEGANY</b>			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			d. STREET ADDRESS <b>418 GRAND AVE.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last <b>EDITH M. VAN METER</b>					Month Day Year <b>MAY 11 1967</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/25/21</b>		9. AGE (In years last birthday) <b>46</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HWF</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>GARRETT, MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JONAS MORELAND</b>					14. MOTHER'S MAIDEN NAME <b>MARY DAVIS</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>216-34-5195</b>		17. INFORMANT <b>HOSP. RECORD</b>		
					Address <b>SACRED HEART HOSPITAL</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>241X STATUS ASTHMATICUS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>BRONCHIAL ASTHMA</b> (c) <b>15 YEARS</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5 - 9</b> , 19 <b>67</b> , to <b>5 - 11</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>5 - 11</b> , 19 <b>67</b> , and that death occurred at <b>3 P.M.</b> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Ralph W. Ballin</i>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>5-11-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>RALPH W. BALLIN, M.D.</b>				22d. ADDRESS <b>62 GREENE ST. CUMBERLAND, MD. 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/14/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maysville</b>			23d. LOCATION (City, town or county) (State) <b>Maysville W. Va.</b>		
24. FUNERAL DIRECTOR <i>Ralph W. Ballin</i>				ADDRESS <b>Westernport, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 18 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

ALPH W. COLLIN, N.B. 62 GREENE ST. CUMBERLAND, MD. 21502

5-11-7

5-11-7

3

5-11-7

5

Y

BRONCHIAL ASTHMA

STATUS ASTHMATICUS

3 DAYS

21-34-2102 HOSP. RECORD SICKED HEART HOSPITAL

JOHN MORELAND

MARY DAVIS

M.F

GARRETT, HARYLAND

U.S.A.

FEMALE WHITE

X

21521

16

EDITH

VAN METER

MAY

11

67

SICKED HEART HOSPITAL

41 GRAND AVE.

CUMBERLAND, MD.

10 HRS.

CUMBERLAND

HARYLAND

ALLEGANY

ALLEGANY

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

06075

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06064

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Mineral</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McCoole</b>		c. LENGTH OF STAY IN 1b <b>Keyser</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Bridge</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Paul</b> Last <b>Viney</b>		4. DATE OF DEATH Month <b>May</b> Day <b>19th</b> , Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1923</b>
9. AGE (In years last birthday) yrs. <b>44</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Hampshire, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Albert Viney</b>		14. MOTHER'S MAIDEN NAME <b>Grace Willis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Annell Viney</b>		Address <b>Keyser, W. Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> <b>3220</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aspiration of Stomach Contents</b> DUE TO (c) <b>Acute alcoholism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>May 19, 1967</b>	
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D. EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 23, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Queens Point Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Keyser, W. Va.</b>
24. FUNERAL DIRECTOR <b>Allen M. Rotruck, Keyser, W. Va.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 22 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06076

06065

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg,</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grantsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners</b>				d. STREET ADDRESS <b>Route 40</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lewis First Middle Last</b> <b>Louis Alfred Walls</b>				4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/16/1915</b>	9. AGE (In years last birthday) <b>51 52X yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lineman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Potomac Edison Co., Grantsville, Md.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Walls</b>				14. MOTHER'S MAIDEN NAME <b>Sally Butler</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW 2</b>		16. SOCIAL SECURITY NO. <b>214-16-2991</b>		17. INFORMANT Address <b>Mrs. Sally Walls, Grantsville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>9148</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Electrocution</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Lineman working on 12000 volt Line</b>					
20c. TIME OF INJURY Month, Day, Year <b>2:45 p.m. May 1 19 67</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Carlos,</b>		20f. (City or town) (County) (State) <b>Carlos, Garrett, Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarolic</b>		M.D. <b>BENEDICT SKITARELIC, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 1, 1967</b> Address (Street, city, town, or county) <b>Cumberland, Md.</b>		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/4/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Menn. Cem. Grantsville, Garrett, Md.</b>		23d. LOCATION (City or Town) (County) (State) <b>Grantsville, Garrett, Md.</b>	
24. FUNERAL DIRECTOR <b>Ruth Newman</b>				ADDRESS <b>Grantsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 5 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06077

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06066

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN Ib		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>			d. STREET ADDRESS <b>Route 4, Oldtown Road</b>		
3. NAME OF DECEASED (Type or print) First <b>Rhoda</b> Middle <b>Rosetta</b> Last <b>Ward</b>			4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 5, 1930</b>	9. AGE (In years last birthday) <b>36</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Jacob Ritchie</b>			14. MOTHER'S MAIDEN NAME <b>Ada Dove</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-30-7960</b>		17. INFORMANT <b>Daniel Ward, Box 283, Route 4, Cumberland, Md</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>330X CEREBRAL HEMORRHAGE</b> DUE TO (b) <b>Rupture of Congenital Aneurysm of</b> stating the underlying cause last. (c) <b>anterior cerebral artery</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 Hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		22. DATE SIGNED <b>May 1, 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 4, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Gardens</b>	23d. LOCATION (City or Town) (County) (State) <b>Near Cumberland Alleg Md</b>	
24. FUNERAL DIRECTOR <b>John J. Hafer, Jr.</b> ADDRESS <b>290 Balto Ave. Cumberland</b>			25a. REC'D BY REGISTRAR <b>MAY 5 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06078

CERTIFICATE OF DEATH

06067

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>50 YEARS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>31 RIDGEWAY TERRACE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>31 RIDGEWAY TERRACE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>W.</b> Last <b>WEBER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>27</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 9, 1882</b>
9. AGE (In years lost birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>01</b> Days <b>11</b> Hours <b>00</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF-EMP.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>PATTERSONS CREEK, W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN WEBER</b>		14. MOTHER'S MAIDEN NAME <b>GERTRUDE GLEICHMAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214 07 1206</b>	
17. INFORMANT <b>EFFIE E. WEBER</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis, Cor. Ar. Ar. Ar.</b> DUE TO (b) <b>Arteriosclerosis, general</b> DUE TO (c) <b>Arteriosclerosis, general</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cor. Ar. Ar. Ar.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 17, 1967</b> to <b>May 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>May 17, 1967</b> , and that death occurred at <b>10:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>David T. Rees</b>		22b. DATE SIGNED <b>MAY 29, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>DAVID T. REES, M.D.</b>		22d. ADDRESS <b>712 MONTGOMERY AVE. CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 29, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. LUKES CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND, MD.</b>	
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>		25a. REC'D BY REGISTRAR <b>JUN 1 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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CERTIFICATE OF DEATH

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THIS CERTIFICATE IS TO BE FILLED OUT BY THE REGISTRAR OF DEATHS IN THE DISTRICT OF COLUMBIA, D.C. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, AND A COPY OF IT IS TO BE SENT TO THE OFFICE OF THE ATTORNEY GENERAL, AND TO THE OFFICE OF THE SECRETARY OF THE DISTRICT OF COLUMBIA. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06073

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06068

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN <b>24</b> years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> <b>01-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>			d. STREET ADDRESS <b>129 West Second St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Edward</b> Last <b>White</b>			4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 14, 1942</b>	9. AGE (In years last birthday) yrs. <b>24</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>1</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fire Co. (Vol.)</b>		11. BIRTHPLACE (State or foreign country) <b>Los Angeles, Calif.</b>	
13. FATHER'S NAME <b>Marshall White</b>			14. MOTHER'S MAIDEN NAME <b>Gladys Newman</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes-Marines 61-65</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Gladys White, Cumberland, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>8154 EPIDURAL HEMATOMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>SKULL FRACTURE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of Motorcycle in Collision with Car.</b>			
20c. TIME OF INJURY Month, Day, Year <b>9:30 p.m. May 10 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Greene Street</b>	
				20f. (City or town) (County) (State) <b>Cumberland, Allegany, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. <b>BENEDICT SKITARELIC, M.D.</b>		22. DATE SIGNED <b>May 12, 1967</b>	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 14, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	
				23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md. Allegany</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>			25a. REC'D BY REGISTRAR <b>MAY 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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UNITED STATES DEPARTMENT OF THE ARMY

OFFICE OF THE CHIEF OF STAFF

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #8 & 9 Film #0391 8/7/67 ph

06080

CERTIFICATE OF DEATH

06069

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>3MO-1WK-3½DA.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>534 A STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>LESTER</b> Middle <b>L.</b> Last <b>WILKINSON</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1891</b> <b>5-18-1891</b>
9. AGE (In years last birthday) <b>76 7/71 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or retired) <b>RETIRED Wholesale Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH WILKINSON</b>		14. MOTHER'S MAIDEN NAME <b>HATTIE ROWLINGS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Hepatic failure</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertrophic cirrhosis Liver</b> DUE TO (c) <b>Coronary sclerosis with myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>100 days</b> <b>1 year +</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cholecystitis &amp; splenic hemorrhage</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>29 May 1967</b> , that (I) (we) last saw the deceased alive on <b>28 May 1967</b> , and that death occurred at <b>5:45 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>W. Alfred Van Ormer, M.D.</b>		22b. DATE SIGNED <b>29 May 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>		22d. ADDRESS <b>122 SO. CENTRE ST, CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/31/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hell Creek Burial Pl.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland MD.</b>	
24. FUNERAL DIRECTOR <b>Louis Stein Inc. - Cumb. MD.</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 1 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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JOSEPH WILKINSON

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

06081

06070

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN lb <b>40 YEARS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital--DOA</b>				d. STREET ADDRESS <b>12 QUEEN CITY PAVEMENT</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>THEODORE B. WILLIAMS</b>				4. DATE OF DEATH Month Day Year <b>MAY 26 1967</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 31, 1903</b>	
9. AGE (In years lost birthday) yrs. <b>63</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE WILLIAMS</b>				14. MOTHER'S MAIDEN NAME <b>VIOLA PORTER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT Address <b>JAMES E. WILLIAMS CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>CORONARY SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> (c) <b>---</b>							INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.				22. DATE SIGNED <b>May 26, 1967</b>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 29, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST BURIAL PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND, MD.</b>	
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>				25. REC'D BY REGISTRAR DATE <b>JUN 1 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06082					06071						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <b>ALLEGANY</b>					a. STATE <b>MARYLAND</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b>					b. COUNTY <b>ALLEGANY</b>						
c. LENGTH OF STAY IN 1b <b>9 HOURS</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MIDLAND</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>					d. STREET ADDRESS <b>MIDLAND, MD. 21542</b>						
3. NAME OF DECEASED (Type or print) <b>ROBERT W. WILSON</b>					4. DATE OF DEATH <b>MAY 5 1967</b>						
5. SEX <b>MALE</b>					6. COLOR OR RACE <b>WHITE</b>						
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>4-20-35</b>						
9. AGE (In years last birthday) <b>32 yrs.</b>					10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONTRACTING WORK</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>MARSH CONTRACTING</b>						
11. BIRTHPLACE (County & State, or foreign country) <b>MIDLAND, MD. 21542</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>						
13. FATHER'S NAME <b>ROBERT WILSON</b>					14. MOTHER'S MAIDEN NAME <b>MARTHA ANN WINTERS</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>					16. SOCIAL SECURITY NO.						
17. INFORMANT <b>HOSP. RECORD</b>					Address <b>SACRED HEART HOSPITAL</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 410X DUE TO (b) <b>Mitral Stenosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Rheumatic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/5</b> , 19 <b>67</b> , to <b>5/5</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>5/5</b> , 19 <b>67</b> , and that death occurred at <b>12:07 AM</b> , from the causes and on the date stated above.										22b. DATE SIGNED <b>5/5/67</b>	
22a. SIGNATURE <b>[Signature]</b>										22c. PHYSICIAN'S NAME (Type) <b>J. A. Pagan, M.D.</b>	
22d. ADDRESS <b>[Signature]</b>										22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>										23b. DATE THEREOF <b>5/8/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>										23d. LOCATION (City, town or county) (State) <b>Frostburg A. Md</b>	
24. FUNERAL DIRECTOR <b>George Eichhorn</b>										25a. REC'D BY REGISTRAR <b>MAY 9 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>											

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SACRED HEART HOSPITAL

ROBERT

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CONTRACTING WORK

ROBERT WILSON

YES

HOSP. RECORD

SACRED HEART HOSPITAL

MARTHA ANN WINTERS

WASH CONTRACTING MIDLAND, MD. 21342

U.S.A.

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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Midland</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Midland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Church Street</b>				d. STREET ADDRESS <b>Church Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROSE</b>		First <b>F.</b>		Middle <b>WINNER</b>		Last <b>WINNER</b>	
4. DATE OF DEATH <b>5/12/1967</b>		Month <b>5</b>		Day <b>12</b>		Year <b>19</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/13/1895</b>	
9. AGE (In years last birthday) <b>71</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Avilton, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Isador Garlitz</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth McKenzie</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Lena Stephens</b>		Address <b>Midland, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO <b>years</b> (c) <b>Diabetes mellitus</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Diabetes mellitus</b>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 9, 1967</b> , to <b>May 12, 1967</b> , that (I) (we) last saw the deceased alive on <b>May 9, 1967</b> , and that death occurred at <b>25</b> M, from causes and on the date stated above							
22a. SIGNATURE <b>L. R. Miles, Jr.</b>		M.D. <b>L. R. MILES, JR., M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5.13.67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. R. MILES, JR., M.D.</b>		22d. ADDRESS <b>LONA CONING MD.</b>		23a. REC'D BY REGISTRAR <b>MAY 15 1967</b>		23b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
23c. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23d. DATE THEREOF <b>5/16/1967</b>		23e. NAME OF CEMETERY OR CREMATORY <b>St. Anns Cemetery</b>		23f. LOCATION (City or Town) (County) (State) <b>Avilton, Md. G.</b>	
24. FUNERAL DIRECTOR <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 15 1967</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06084

CERTIFICATE OF DEATH

06073

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN 1b <b>3 WEEKS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS HOSPITAL</b>		d. STREET ADDRESS <b>24 DEPOT ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>EDNA</b> Middle <b>E.</b> Last <b>WOLFORD</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>20</b> Year <b>19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 30, 1890</b>
9. AGE (In years last birthday) yrs. <b>76</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BARTON, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM EDWARD PHILLIPS</b>		14. MOTHER'S MAIDEN NAME <b>NORA ROSS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-07-1633B</b>	
17. INFORMANT <b>MR. ODIS WOLFORD, 24 DEPOT ROAD</b>		18. FROSTBURG, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral occlusion secondary to</b> DUE TO <b>arteriosclerotic Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic Cardiovascular disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day - 1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>66</b> to <b>May 20</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>May 20</b> , 19 <b>67</b> , and that death occurred at <b>11</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>John B. Davis, M.D.</b>		22b. DATE SIGNED <b>5/22/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN B. DAVIS, M.D.</b>		22d. ADDRESS <b>2 BROADWAY, FROSTBURG, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 23, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>MARILOU M. SOWERS, HAFFER-SOWERS FUNERAL HOME</b>		25. REC'D BY REGISTRAR <b>MAY 25 1967</b>	
26. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		27. REGISTRAR'S NAME <b>Charles Judge</b>	

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THE HOUSE OF REPRESENTATIVES

OFFICE OF THE CLERK

WASHINGTON, D. C.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06085

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06074

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - FROSTBURG</b>		c. LENGTH OF STAY IN 1b <b>SEVERAL HOURS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOFFMAN ROAD</b>		d. STREET ADDRESS <b>ROUTE #1, BOX 74</b>	
3. NAME OF DECEASED (Type or print) <b>Judy Lee Ziegler</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>28</b> Year <b>19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 17, 1947</b>
9. AGE (In years lost birthday) <b>20</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>KARL H. ZIEGLER</b>		14. MOTHER'S MAIDEN NAME <b>MARY MARGARET LEWIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>167-40-9585</b>	
17. INFORMANT <b>KARL H. ZIEGLER-RD#1, BOX 74, SALISBURY, PA.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>953X</b> IMMEDIATE CAUSE (a) <b>CRUSHED SKULL</b> DUE TO (b) <b>(INFLICTED BY ASSAILANT)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>ASSAILAINT STRUCK REPEATED BLOWS WITH ROCKS</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>1</b> p.m. <b>MAY 28 19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hoffman Road</b>		20f. (City or town) (County) (State) <b>Near Eckhart, Allegany, Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		22. DATE SIGNED <b>MAY 29, 1967</b>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		Address (Street, city, town, or county) <b>CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MAY 31, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST BURIAL PARK</b>	23d. LOCATION (City or Town) (County) (State) <b>NEAR CUMBERLAND, ALLEGANY, MD.</b>
24. FUNERAL DIRECTOR <i>John J. Hafer, Jr.</i>		25a. REC'D BY REGISTRAR <b>JUN 5 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

06086

06075

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY in lb <b>37 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>413 PALASKI STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MYRTLE</b> Middle <b>E.</b> Last <b>ZIMMERMAN</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>14</b> Year <b>1967</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-14-1900</b>		9. AGE (In years last birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WIFE.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HENRY LITTLE</b>				14. MOTHER'S MAIDEN NAME <b>ROSE RICE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-24-1274B</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial heart failure &amp; fibrillation</b> 4331 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Generalized arteriosclerosis</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary infarction; Acute saddle embolus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1959</b> , to <b>5-14</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>5-14</b> , 19 <b>62</b> , and that death occurred at <b>2:05 A.M.</b> on the date stated above.							
22a. SIGNATURE <b>William P. James</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/15/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>WM. P. JAMES</b>				22d. ADDRESS <b>441 NO. CENTRE ST. CUMBERLAND, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/16/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Maryland</b>	
24. FUNERAL DIRECTOR <b>H. Lee Silcox Cumberland Maryland 21502</b>				25a. REC'D BY REGISTRAR <b>MAY 17 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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ALLIANCE

WARRIORS

STARS

C. HENRY

ALASKA STREET

MEMORIAL HOSPITAL

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ST. MARKS

E.

WYRTLE

IN 1900

LEWIS WHITE

HARRY AND

NEED

ROSE RICE

HENRY LITTLE

NEW YORK MEMORIAL HOSPITAL, CUMBERLAND, N.Y.

NEW YORK

NO

*[Faint, mostly illegible handwritten text and markings, including a large circular stamp or signature in the center.]*